



**RBM Harmonization Working Group
Country briefing document for
Global Fund Round 10:**

Malaria Proposals

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1. Overview of key issues

Proposal period

The Global Fund round 10 runs from May 20th to August 20th 2010. Please note that this is a shorter window than normal. The mock Technical Review Panel will be held in Entebbe 29th June -1st July.

Prioritisation

For round 10, the Global Fund has introduced the following prioritisation criteria:

Criteria	Indicator	Value	Score
TRP Recommendation	TRP Recommendation Category	Category 1	4
		Category 2	4
		Category 2B	3
Disease Burden	Specific disease burden criteria set forth in paragraph c below		4
			3
			2
			1
Poverty	World Bank Classification	Low Income	4
		Lower-Middle Income	2
		Upper-Middle Income	0

Malaria Burden is estimated as follows:

Indicator	Value	Score
Combination of mortality rate per 1,000 persons at risk of malaria; morbidity rate per 1,000 persons at risk of malaria; and contribution to global deaths attributable to malaria***	Mortality rate ≥ 0.75 and morbidity rate ≥ 10 OR Contribution to global deaths $\geq 1\%$	4
	Mortality rate ≥ 0.75 and morbidity rate <10 OR Mortality rate ≥ 0.1 and <0.75 regardless of morbidity rate	3
	Contribution to global deaths $\geq 0.25\%$ and $<1\%$ OR Mortality rate <0.1 and morbidity rate ≥ 1	2
	Contribution to global deaths $\geq 0.01\%$ and $< 0.25\%$ OR Mortality rate <0.1 and morbidity rate <1	1
	Contribution to global deaths $< 0.01\%$	

*** Source of data: WHO

It is important to note that countries which are lower middle income/middle income and low malaria burden will be disadvantaged in the prioritisation for round 10. Low burden and low income countries will not be disadvantaged.

It should also be noted that the introduction of prioritization criteria in round 10 indicates that there are relatively limited resources available for round 10 proposals.

2. Key issues raised by the technical review panel and recommendations on how to address these

A review of TRP feedback to countries has revealed a good understanding of the key issues that the group of technical review panellists base their proposals rating decisions on. It appears that strong proposals include a good description of the process by which the proposal was developed, and that the TRP values consultative proposal development processes that include key stakeholders from all sectors, public, private and civil society. Value is also placed on showing clear linkages with existing GF grants. It is also important to request funds to support sound and feasible technical interventions which are consistent with the national strategic plan and in line with regional and global disease control targets and best practices. In doing this, a good epidemiological description, supported by a well-documented program analysis is needed. Coherency, sound analysis, well articulated goals, specific objectives and a good description of the interventions; beneficiaries and the sustainability are the key assets to the overall success of the process.

On disease control, a theme that is picked up as positive relates to clear linkages to other grants. In cases where an intervention is being introduced for a first time, piloting and making clear that lessons will be learnt in a phased implementation approach are all good score points. Concerns include poor quantification of ACTs and RDTs, particularly relating to observed changes in epidemiology or disease burden. For example, the quantification of drug procurement based solely on estimates of incidence without consideration of systems and capacities is seen as inappropriate, whilst in equal measure, estimates for commodities must take into consideration the expected drop in malaria incidence following scaling up of preventive interventions.

On vector control, a good malaria epidemiological stratification of the country or region, with clear demarcation of where the different vectors control strategies would be deployed, is seen positively by the TRP. It also helps to have in place initiatives to evaluate the potential impact of insecticide(s) on the environment and to monitor the dynamic of insecticide resistance. In cases where IRS and LLINs are proposed as joint and or concurrent interventions, clarity is needed to explain the added advantage of one and then the other, if applied in same locations. Positive remarks are made in cases where such dual interventions follow WHO guidance. On LLINs, quantification, good definition of target population, and distribution methodology are all issues that when not well articulated tend to contribute to poor proposal ratings.

An important part of the proposal is the section on budgets. In the worst rated proposals, the TRP usually states that, there are discrepancies in the budget, financial gap analysis are poorly done, there is a lack of details, and in some cases unit costs are over and above standard known costs - these are all issues that go to question the credibility of the proposal. Inconsistency in calculations, inflated costs, lump sum figures not well explained and poor budgeting do not receive good reviews from the TRP. Clarity, good budget notes, good estimates, detailed breakdown of costs and assumptions and sound believable justifications earns more positive assessments.

With regards to BCC/IEC, the perennial issue relates to the provision of evidence of the effectiveness of the intervention. Over and above this, positive reviews include sound and evidence based activities, integrated strategies, which demonstrate the

intended impact on the population, with strong qualitative and quantitative evidence of impact. It does help to show the involvement of and ownership of communities, civil society organizations and linkages with previous BCC/IEC activities in previous grants.

The review looked at the TRP feedback on alignment of proposals to the national strategy and policy orientations, as well as the nature and strength of national M&E systems, the specific proposal indicators and the M&E platform related to the proposal. Proposals need to have well articulated activities and sound measurable indicators building on a comprehensive implementation strategy rooted in a well-developed national M&E plan and framework. Objectives, service delivery areas and indicators should, in keeping with the focus of the proposal also ensure that they are aligned to the broad national strategic orientation, and contribute to this as well as answering to the specific needs of the proposal. It helps to analyze the strengths and weaknesses of the national system and devise ways to strengthen the M&E system to benefit the data quality and timeliness of reporting. A good understanding of the different levels of indicator formulation and measurement (input, process, output and impact) are an asset. The establishment of baselines and how indicators will be assessed and measured are necessary. Care must be taken to streamline and coordinate to benefit from planned surveys and studies.

Of equal importance is a need to clarify the procurement system in place and proposed. The proper quantification of needs with realistic values is important; focus must be placed on a good description of the procurement arrangements, its strengths and weaknesses. In cases where inherent and persistent PSM weaknesses are the order of the day, the TRP sees value in opting for the GF's Voluntary pooled procurement system.

A key area of interest is the management and implementation arrangements that are proposed to manage the proposal. Here a good description of the implementation arrangements, the coordination mechanism, and the overall impact or effect of the existing health systems is necessary. In cases where previous grants have been awarded, a history of the implementation arrangements, lessons learned and any modifications are also important to make. The selection of principal and sub-recipients must show transparency and cross sectional representation, from Government, faith-based, civil society and the private sector where applicable. The proposal's chances are enhanced when there is clarity in the responsibilities and activities of the key implementer's capacity to deliver. The national architectural platform for programme implementation, such as SWAPs and others must be highlighted, especially where that implementation arrangement will affect the proposal. A history of previous grants, AND their performance must also be articulated, more importantly, in cases where it is envisaged that the current proposal may be merged with existing grants, this must be highlighted.

See ANNEX for detailed comments

3. *Key lessons learned by HWG from previous rounds and recommendations for filling out proposal*

- **Guidelines.** In past rounds, we have noted that many read the guidelines once at the beginning of proposal drafting, and then not again. We strongly suggest that you keep the guidelines by your side at all times, and refer to them often. Please also use the checklists provided for you in the proposal form. Also note that the guidelines have been extensively updated since round 9 and we recommend that all involved in completing the proposal forms are familiar with them.
- **Gap Analyses.** The gap analysis tables (formerly table 4.4 in round 8 and 9) have been removed from the round 10 template. However, we strongly recommend that a clear gap analysis is carried out during the preparation of the proposal. We have found from past experience that this helps with prioritization of activities and identification of targets, gaps and needs. This gap analysis should include an explanation of the underlying assumptions and can be attached in annex to the proposal. This gap analysis should be brought along to the mock TRP.
- **Universal coverage.** Countries should budget for 100% coverage, when aiming for 80% utilization of LLINs, ACTs, RDTs or IRS
- **Comments from TRP.** It is essential that each country directly responds to the comments made by the TRP from the last Global Fund submission even if the country is not resubmitting the same application. These comments should be included in the template and in an attached summary.
- **Impact of prevention coverage on ACT forecasting.** After the 80% vector control utilization target* is reached, countries should budget for reductions in ACT consumption. Where in country data exists, we strongly recommend that this should be used. Where data is unavailable, as an interim recommendation, we suggest a 10% reduction in ACT procurement for the year following the achievement of universal coverage. Assuming coverage is maintained, 20% reduction can be assumed for the year after that, and 30% the year after that. This is an interim solution recommended by the RBM HWG, and it is recommended that countries collect data to refine forecasts in future years.
- **Selection of Principal Recipient.** Principal Recipients must be competitively selected, with the process clearly documented. Simply noting that the Government will be the PR, without a documented competitive process will not be acceptable. We also recommended that there are 2 PRs – one from Government and one from Civil Society (Dual Track Financing). Whilst this is not mandatory, a justification must be submitted as to why you have chosen not to.
- **Presentation of the Proposal.** The TRP takes, on average, about 3 hours to read and decide on each proposal. We have found that graphs, pictures, visuals are very effective ways of communicating information to the TRP, and helps avoid any translation errors.
- **Tables less relevant for malaria.** We have found that some tables for example Table 4.2.d: Malaria epidemiology of target populations may be difficult/not

possible to fill in, and are largely not relevant for malaria. If you decide to leave them blank, we strongly suggest you include a line stating that “These data are not available and not collected by the country”...or something like it. Please don’t leave this table (or any table) blank without an explanation, as the TRP may think you’ve just forgotten to fill in the table.

4. Key technical updates: WHO

For a comprehensive summary of key technical recommendations, please refer to the accompanying document: Malaria Global Fund Proposal Development: WHO POLICY BRIEF May 2010. See also A COMPILATION OF WHO REFERENCE MATERIAL attached.

5. Key Implementation issues:

LLIN Scale Up – Elements for Inclusion and Key Lessons Learned for Planning and Budgeting

Coordination

- Attending meetings is a part of regular work service. No per diems should be paid, though allocation can be made for refreshments for participants.
- Key planning meetings should be budgeted for – finalizing and validating the plan of action, finalizing all training and data collection materials, post-distribution wrap up meeting.

Procurement

- Budget for any costs for in-country activities (e.g. advertising call for tenders, publishing results of the bid analysis, meeting of procurement committee to review bids [refreshments]).

Logistics

- Need to determine if costs for clearing customs and initial warehousing are part of procurement. If not, need to be included in logistics budget. Port costs will vary – scanning of containers or no, container inspection, administrative fees and insurance should all be considered.
- Budget for micro planning (including training) for the central team to support the lower levels to ensure accurate information collected.
- Ensure adequate transportation and secure storage for LLINs. This may involve small repairs to warehouses and payment of security staff for the duration of the storage period.
- Be sure to budget for the training of all personnel involved in the logistics operation. Supply chain management is dependent on having the right documentation and knowing how to use it.
- Supervision missions for the central logistics team and the regional / district logistics personnel are key for ensuring adequate management of the supply chain.

Advocacy / Communication / Social Mobilization

- Communication should not be underestimated in the budget. It is important that activities take place before, during and after the mass distribution.

- Include adequate planning for mass media (posters, radio, television, banners, etc) and also for interpersonal communication.
- Communication activities need to be supervised and monitoring should be done to assess to what extent the beneficiaries have accepted and understood key messages that have been passed.
- All briefing sessions (Government, media, regions, districts) should include a budget for ensuring participation of stakeholders (refreshments, transportation and per diem if absolutely necessary).

Identification of Beneficiaries

- Regardless of distribution strategy, it is necessary to include a line for the identification of beneficiaries.
- In calculating needs for personnel for the identification of beneficiaries (household registration), consider adding a margin of error to the number of households (as calculated from recent census data and average household size). Adding the margin of error will ensure adequate personnel, even in hard to reach areas.
- In general, it will take 10-15 minutes for a health worker to register a household. Based on that timeline, you should estimate personnel needs by considering that one person can cover 20-30 households per day. The number of days of the household registration will determine the number of people required to complete the activity.
- Be sure to budget for the training of all personnel involved. Keep in mind that the identification of households is key for the distribution. You should determine the number of training days accordingly.
- If you are using vouchers, bracelets or other means for identification of beneficiaries, be sure to include these elements in the budget.
- Data collection tools need to be in the budget.

Distribution

- The number of people required for the distribution will depend on how the sites are organized (e.g. grouping multiple villages, having mobile sites, etc).
- You should ensure that you budget for adequate personnel, including crowd control and health education, at all sites.
- Urban distribution sites will, in general, require more personnel, notably for crowd control.
- If distribution is door-to-door, you should estimate the amount of time per household and determine personnel needs accordingly.
- Training and data collection tools need to be included in the budget.

Hang Up (ensuring utilization)

- It is important to determine what you will do to ensure utilization of the LLINs distributed.
- Hang up of nets can be promoted either through mass media or through interpersonal communication. The strategy should be based on existing knowledge of the country's "net use culture".
- For low net use countries, it may be important to have house-to-house visits prior to peak transmission periods to ensure that vulnerable populations are covered. In countries with high net use, radio messaging prior to peak transmission periods may be sufficient.

Evaluation

- Post-distribution evaluation should be included in the budget for LLIN specific information. The evaluation should fit within the existing NMCP M&E plan.
- Post-distribution evaluation should include retention / coverage / utilization, but should also look at effectiveness of communication activities.
- Evaluation should be used to feed into the overall communications plan for ensuring high utilization of LLINs.

(See ATTACHED SPREADSHEET)

LLINs Routine

Importance of routine delivery

Although mass campaigns are an excellent way to scale up LLIN coverage quickly and equitably, they should be complemented by some form of routine delivery to ensure that coverage and utilization rates are sustained. Routine delivery makes LLINs accessible to populations in between campaign years, thereby replacing damaged/worn/lost campaign LLINs and covering newly born children and newly pregnant women who weren't accounted for in the campaign. Diversifying LLIN delivery channels increases the opportunity to maximize sustainable coverage to all age groups, thus helping to maintain universal coverage. Routine delivery also creates an additional, valuable opportunity to reinforce BCC messages on proper LLIN utilization. Finally, it is good practice for countries to create national systems to deliver LLINs steadily and sustainably to the population. Countries that have fully scaled, robust routine delivery in the public and private sectors may be able to phase out nationwide campaigns in the future.

Options for routine delivery

LLINs can be distributed routinely via public sector channels, private sector channels, and public-private combinations.

LLINs distributed at full cost through the private sector favour populations of higher socio-economic status, rarely reaching populations who are most at risk for malaria. Therefore public sector or public-private sector delivery are preferred to purely private sector delivery.

Public sector channels deliver LLINs through ANC (antenatal care) clinics and EPI (expanded program on immunization) clinics to pregnant women and children under 5 or under 1, respectively. These LLINs can be distributed either free of charge or at a highly subsidized price. Any fee charged can be used to support facility activities/upkeep or it is given to the health care providers as an incentive. Storage of LLINs is generally not a problem, as clinics usually have a dry, secure corner of the clinic that can be used for LLINs. A positive by product of LLIN delivery through ANC and EPI clinics is that the free LLIN can encourage increased clinic attendance to ensure that patients receive other important interventions.

Public-private combination channels such as social marketing deliver LLINs at subsidized costs through commercial channels. The advantage of social marketing is that anyone with access to a vendor can obtain a net, including adult males who do not attend ANC or EPI clinics. In some cases, such as in Tanzania, the public sector can distribute vouchers to highest risk populations through ANC and EPI clinics, which are then used to receive a bigger discount on the socially marketed net in the market. In countries where the public sector is weak and health facilities cannot be

relied upon to distribute LLINs consistently, social marketing may be the next best option for routine delivery. The disadvantage of using markets is that even a small fee will be a barrier to the poorest of the poor. Additionally, due to the bulky nature of LLINs, the inconvenience of storing LLINs in small kiosks might lead to frequent stock outs. Generally, social marketing activities are a good complement to free distribution programs where free nets are targeted at high risk groups, but the whole population can access socially marketed nets.

In either option, messages on correct and consistent LLIN utilization via mass media as well as via inter-personal communications must accompany the delivery of LLINs. In public sector channels, the very valuable nurse-patient contact can be leveraged.

Routine delivery via public sector clinics, such as ANC and EPI:

While a mixture of public and public-private delivery channels will maximize LLIN access, routine delivery via public sector clinics is the “lowest hanging fruit” with the greatest capacity to improve coverage among highest risk populations. High-transmission malaria countries should seriously consider making LLINs available at low or no cost in all health facilities, as part of the national malaria control program. It’s important to note that in order to develop a sustainable routine delivery mechanism, a number of factors need to be considered.

- A functional public sector with a supervision system that will ensure nurses deliver LLINs according to the program objectives
- A system of patient cards that can be marked once a net is received by the patient
- Routine distribution relies on good infrastructure to maintain supply. Outlets included in any programme should be accessible to delivery vehicles in order to maintain supply. In some cases other forms of transport such as trains or boats may be needed to be included in logistics plans.
- The ANC and/or EPI attendance must be relatively high in order to reach a large enough proportion of the population. In most sub-Saharan African countries, ANC attendance is well over 80%.
- At each level of the distribution chain, funds should be budgeted for storage, management and security of supplies.
- There must be a coordinator in each region/district to manage the logistics of the program and ensure that the continuity of supply is not interrupted by stock outs.
- MoHs may want to consider subcontracting the logistics and day to day management of a routine LLIN system to reduce the administrative burden on malaria control programs. The MOH and the districts health management teams can still oversee the program and supervise the health workers distributing the LLINs, but don’t have to deal with the logistics.

- No matter what channel is used for LLIN distribution, sufficient funding for BCC activities is needed to ensure correct usage. BCC materials should be tested and continually developed to ensure their effectiveness.

Please see the AMP LLIN toolkit (to be released in July 2010) at www.allianceformalariaprevention.com/resources.php for more guidance on routine delivery of LLINs. Topics covered include quantifying LLIN need, mapping of health facilities, training of health workers (on both net delivery and communications on net use), distribution chain, job aids, supervision, and M&E.

6. Changes to round 10 form and recommendations on how to address them: Overview

There are a number of changes to the round 10 proposal guidelines:

- **Guidelines.** The guidelines have been extensively updated since round 9 and we recommend that all involved in completing the proposal forms are familiar with them. Keep the guidelines by your side at all times, and refer to them often.
- **Programmatic gap analysis.** The gap analysis tables (formerly table 4.4 in round 8 and 9) have been removed from the round 10 template. We recommend that a clear gap analysis is carried out during the preparation of the proposal. This helps with prioritization of activities and identification of targets, gaps and needs. When the gap analysis is not clear, the proposal is also not clear. This gap analysis should include an explanation of the underlying assumptions and can be attached in annex to the proposal.
- **Value for money** (see section below): this will include a justification of commodity unit costs and, where available, the cost of services. It is recommended that where data are available on service delivery costs, countries should include detailed justifications of what contributes to these costs including DSA rates, storage and transport costs etc, particularly in countries where operations are known to be expensive. It will also be important to justify the value of using more than one intervention, for example, the use of LLINs and IRS in the same districts. Where data are not easily available, countries should outline how these data will be collected.
- **Optional consolidation (see section below):** as the global fund moves towards consolidation of grants and single stream financing, round 10 will allow countries to indicate whether they intend to begin consolidation of existing grants with the round 10 application using the consolidation attachment to the proposal form. If the country chooses not to apply in a consolidated manner, it may indicate whether or not it plans to consolidate as part of the grant signature and negotiation process. It is important to note that while consolidation is an option for Round 10, it will be mandatory beginning Round 11 as the “single-stream of funding”, which is central to the Global Fund’s new architecture, is rolled out. While many countries may ultimately consolidate, given the limited proposal development period for Round 10, the HWG recommends that for most countries it may be easier to indicate that the country wishes to consolidate as part of the grant signature and negotiation process.
- **Costed TA plan. For the first time, countries will be required to submit a costed technical assistance plan outlining TA requirements.**

- **Financial gap analysis:** there is an increased emphasis on the contributions of others and issues around sustainability and countries should emphasise the contributions of other partners.
- **Gender Equality Strategy:** provision of sex disaggregated data (see below)
- Community Systems Strengthening (CSS) - strengthened Proposal Form and Guidelines to provide CSS-specific service delivery areas (see below)

Value for Money

As noted above, it is critical that applicants refer to the guidelines on this topic when completing this section. In addition, guidance is provided at http://www.theglobalfund.org/documents/rounds/10/R10_FAQ_en.pdf

In the Round 10 documentation, the Global Fund has defined what it means by Value for Money (VFM) for the first time, as well as how it will be evaluated in the proposal.

Value for money (VFM) has been defined as using the most cost-effective interventions, as appropriate, to achieve the desired results. While there are some short term and fairly standardized components of VFM, for example the cost of commodities, other elements, such as quality and sustainability, are more subjective and difficult to measure. When reviewing proposals, the Technical Review Panel considers “value for money” in addition to a range of criteria such as past program performance, implementation capacity, and an epidemiological evidence base for the proposed activities. The focus within value for money is to maximize the impact of technically appropriate and operationally feasible investments with the available resources.

Having an understanding of value for money of the program being implemented, particularly its service delivery unit costs for key interventions, provides an opportunity to examine where the leverage points for improvement are: can the same program produce more of same quality with the same amount of money if some cost components could be brought down? Can the program produce better quality or more outcomes of same quality with the same cost? Can some additional cost provide significantly better quality or secure sustainability?

Value for Money has been integrated into the Round 10 proposal form in the following sections:

- New question and guidance on improving VFM (4.5.3). In this section, applicants need to explain how the overall program provides value for money and how the proposal contributes to it. In this section the applicant should also consider context-specific factors beyond the immediate cost of the program (to the provider) particularly on the value side: why is the approach chosen in the program context the best value, taking into account the maturity of the program, the stage of the epidemic, the patient mix to be served with the grant funds, and the sustainability of the system supporting it.
- Reference to VFM and additionality in Program Sustainability section (4.5). In this section, it is important that applicants provide plans which will support the sustainability of impact of the Global Fund supported interventions in the country.
- Specific reference to VFM on pharmaceutical procurement (4.8). In this section, “Pharmaceutical and health products for initial two years”, provide

justification for the unit costs used for budgeting for key health commodities in the procurement plan. The prices should be justified by published international reference prices [links to relevant web pages].

- New reference to additionality in the context of financial needs (5.1.1); In this section, “Additionality of Global Fund request”, applicants should provide evidence of additionality, such as through complementary investments by the applicant and through supporting documents.
- New question on measuring unit cost and cost effectiveness (5.4.4). In this section, “Measuring service delivery unit cost”, applicants need to consider for what key intervention the service delivery unit costs will be measured and linked to data on health impact at times of periodic reviews of the program. Include the measurement in the workplan and budget of the proposal if seeking Global Fund funding.

For commodity unit costs, reference prices (and ranges) have now been provided for LLINs and ACTs. In addition, web links to standard reference prices (and ranges) have also been provided. If the expected commodity unit costs fall within the ranges provided, the applicant must justify why. The HWG recommends that applicants budget for LLINs and ACTs within the reference ranges provided, wherever possible.

Applicant will be asked to estimate the service delivery costs in section 5.4.4. Specific examples of how these can be calculated will be available at (www...). The intent of this section is to understand the full cost of delivering the key services proposed in the proposal (e.g. LLIN distribution), not only the commodity costs, so that the TRP can determine whether or not the costing is reasonable given the expected impact.

For more information on Global Fund and value for money, please visit:

Information Note:

http://www.theglobalfund.org/documents/rounds/10/R10_InfoNote_VfM_en.pdf

Guidelines:

http://www.theglobalfund.org/documents/rounds/10/R10_Guidelines_Single_en.pdf

THE HWG RECOMMEND THAT WHERE COST OF SERVICE DELIVERY DATA ARE PROVIDED THAT THESE ARE WELL JUSTIFIED WITH SUPPORTING DOCUMENTATION, FOR EXAMPLE GOVERNMENT AND PARTNER AGREED DSA RATES; STANDARD DELIVERY AND TRAINING COSTS ETC.

Consolidation

Applicants will be requested to indicate whether they intend to consolidate existing grants with this proposal during grant negotiation. Consolidation refers to the situation where multiple grants can be combined to form one grant. Consolidation is possible if a Principal Recipient (PR) is already managing at least one grant and the applicant is approved for an additional grant for the same PR and same disease. After a review of its grant architecture, the Global Fund is transitioning toward single

streams of funding per PR per disease. This means that each existing PR will have one grant agreement with the Global Fund per disease, regardless of how many grants that PR currently has for that disease. Single streams of funding per PR per disease are intended to create a number of efficiencies for the applicant and the respective Principal Recipients.

For Round 10:

- Applicants will be presented with two options related to how they wish to voluntarily transition to a single stream of funding, as well as one additional option available for applicants who choose not to transition to a single stream of funding.
- If applicants choose to consolidate at the proposal level, they will be requested to provide various narrative descriptions of their consolidated programmatic information, as well as a Consolidated Performance Framework.
- Specific financial information on the consolidated disease proposal's incremental demand will be determined by the Secretariat in a collaborative effort between the applicant, and Secretariat during the period between proposal submission and TRP review.
- Specific information on periodic review (which will replace Phase 2 reviews in the new architecture), particularly the date of periodic review, will be requested and discussed during grant negotiations.

Applicants that are successful in their consolidated disease proposal will have the opportunity to sign their grant into a single stream of funding at the time of grant negotiation. A single stream of funding simply takes all grants in a disease area currently managed by a single Principal Recipient (PR), adds any new funding received for that PR through the Round 10 approved proposal, and converts the totality of that funding into one grant agreement, which is called a "single stream of funding" grant agreement.

In the proposal form itself, countries will have three clear options presented in Section 3.1:

Option 1: Tick the box to select this option if the applicant plans to submit a consolidated disease proposal and sign a single stream of funding grant agreement(s) during grant negotiation, if approved. It is important to note that the following two criteria must be satisfied or the submission will not be reviewed as a consolidated disease proposal:

- (i) a consolidated disease proposal must include all same-disease grants that will have at least 12 months of implementation remaining on the grant from the planned start date entered in section 3.2 of the Proposal Form;
- (ii) a consolidated disease proposal must include all same-disease grants for all Principal Recipients in the applicant's Global Fund portfolio, regardless of whether changes to the scope of those activities is planned.

Option 2: Tick the box to select this option if the applicant plans to transition to a single stream of funding by consolidating existing Global Fund grants with the Round 10 proposal during grant negotiation.

Option 3: Tick the box to select this option if the applicant does not plan to submit a consolidated disease proposal nor do they plan to transition to a single stream of

funding by consolidating existing Global Fund grants with the Round 10 proposal during grant negotiation. In Round 10, the applicant may voluntarily transition towards a single stream of funding per PR per disease by:

(1) opting to consolidate existing Global Fund grants with the proposal, conditional upon its approval; or

(2) submitting a consolidated request for funding through the use of the consolidated proposal form. If an applicant intends to submit a consolidated request for funding, then the applicant should refer to the Round 10 Guidelines [Consolidated].

While the HWG is fully supportive of the new architecture and a shift to a single stream of funding, for most countries, Option 2 will be the most appropriate option (if there are existing grants managed by the proposed PR that have at least 12 months left of implementation). This will indicate a desire to consolidate and enter a much simplified structure, but would not place additional pressure on an already compressed proposal submission period.

7. Cross cutting issues

Refugees and emergencies

Populations affected by Humanitarian Emergencies

Rationale:

Up to 30% of malaria deaths in Africa occur in the wake of war, local violence or other emergencies.¹ Countries impacted by chronic humanitarian crisis are of strategic importance as well. The massive population displacement that usually accompanies humanitarian crises is likely to lead to an increase in malaria morbidity and mortality. Resource limitations, inaccessibility, insecurity, inadequate infrastructures and lack of capacity are barriers to carrying out effective malaria control and prevention programmes in such settings. Humanitarian crises and other emergencies can undermine pre-existing malaria control measures and lead to a collapse of health services.²

To achieve the goals of the RBM Partnership, especially in the scale-up and sustained control stages, efforts must be made to control malaria in emergencies and humanitarian crisis, as these situations may quickly lead to a loss of the benefits achieved by the malaria control programs.

Definition: Populations affected by humanitarian crisis

Humanitarian crisis are referring to either manmade conflicts or natural disasters that result in either a large part of a population being displaced and/or unable to carry out their normal lives due to the breakdown or incapacitation of infrastructures and cut-off from accessing essential needs and services.

¹ *Guiding principles for malaria control in acute and chronic phase emergencies in Africa, Conclusions of WHO / Roll Back Malaria Consultation*, Geneva, World Health Organization, 15 November 2004.

² The Global Malaria Action Plan: For a malaria-free world, Roll Back Malaria, Geneva, 2008

Populations affected by humanitarian crisis include displaced persons such as refugees and IDPs, their hosting communities, returning displaced populations as well as non-displaced populations living in areas affected by conflict and/or natural disasters. Conflicts and/or disasters can have long-term consequences, such as protracted displacement situations in which populations remain dependant on external assistance.

Epidemiology of malaria in humanitarian crisis

Conflicts and/or natural disasters have the potential of altering the epidemiology of malaria. In areas where significant advances have been achieved in reducing the transmission and disease burden due to concerted control efforts, humanitarian emergencies are likely to halt if not revert such progression because of interruptions to the control programme interventions. Large scale population movements can lead to a change from a stable transmission to an unstable transmission and increase the risk of epidemics because of a change in population density, deteriorating living conditions, inaccessibility of health services and prevention programmes can not be accessed by the population malaria and hence.

Natural disasters, especially floods and torrential rainfalls increase the likelihood of epidemics or lead to a medium to long-term amplification of transmission.

Response to humanitarian crisis and malaria programmes in humanitarian settings

The response to humanitarian crisis is coordinated by the Office for the Coordination of Humanitarian Affairs (OCHA) and structured within 11 clusters covering key technical areas and assistance aspects of the coordinated humanitarian response. In addition, UNHCR is mandated to provide assistance to refugees, those displaced across national borders.

Humanitarian funding mechanisms are in place to make available the initial resources needed to enable the provision of essential assistance during emergencies and the stabilisation phase. However, because of limited funding but overwhelming needs, such initial response mechanisms usually aim to cover the essential needs at the level of minimum international standards in humanitarian settings and for a limited time only.

Malaria control programmes are not as such part of the initial humanitarian response. In endemic areas, malaria is included as curative aspect under primary health care with access to early diagnosis and effective treatment being characteristic focus areas. Data from UNHCR's health information system (HIS) shows that 97% of all major refugee operations in malaria endemic areas have adopted ACT as 1st-line treatment, thus following in large part national protocols. However, only 44% of all malaria cases are laboratory confirmed (microscopy/RDT).

Note that this data represents UNHCR refugee operations in 17 countries only. This is not a representation of the approach to early diagnosis and treatment of malaria in humanitarian crisis in general.

The distribution of long-lasting insecticide-treated bednets (LLIN) is often not prioritised on during humanitarian emergencies. However, LLIN coverage among populations affected by conflict or natural disaster should be considered a priority, notably because displaced settings leave people vulnerable in terms of shelter, food and nutrition, water and sanitation and access to health care.

Why include these populations into Global Fund proposals

In order to achieve universal coverage by 2015 as set out by the GMAP, malaria control and prevention programmes should embrace all vulnerable populations. Furthermore, in order for control interventions to be evidence-based and scientifically sound, risk factors such as conflicts and/or natural disasters must be taken into account.

Humanitarian funding mechanisms most commonly only cover the essential needs for a limited time. Global Fund grants on the other hand are situation unspecific and less time sensitive, hence can be shaped to bridge vital funding gaps between humanitarian short-term funding and long-term funding to pursue strategic objectives such as those of the Global Fund and Roll Back Malaria.

Considerations for proposal writing

Agree with stakeholders and CCM members to include populations of humanitarian concern such as displaced persons and refugees as part of the target populations in the proposal.

In refugee-hosting countries and countries with internally-displaced populations, ensure that these are part of the national malaria strategic plan; if not negotiate to have an addendum including that or make it clear that in targeting universal coverage this includes the targeting of all populations including the displaced.

Countries affected by recurring natural disasters (floods, draughts, Tsunamis, earthquakes etc) or latent and/or acute conflicts should furthermore take account of making provisions in their proposals for contingency plans that alleviate the effects of such situations.

Arguments to support these notions can be made on technical (epidemiological) grounds as well as with reference to humanitarian populations in the GMAP. It should furthermore be emphasised that the inclusion of disaster or conflict affected populations does not take away resources from programming needs for non-affected populations, but rather requires additional resources.

Proposal Process/ Structure	Action Point
2.2.2 Transparent proposal development processes	Ensure that actors concerned with refugees and emergencies are included in the proposal development process. It may be useful to identify a focal point to ensure that refugee and emergency issues are sufficiently highlighted
2.2.4 Principal Recipient(s) or sub recipients	Where appropriate identify key organisations to act as PR or SR for humanitarian populations/issues
3.5 Summary of Round 10 Proposal	Ensure that reference is made to the inclusion of humanitarian populations/ issues.
4.2.1 Geographic reach of this proposal b) Size of population group(s)	Ensure to include geographic locations and population sizes (known or estimated) of populations affected by humanitarian situations
4.3.1 Malaria program	Highlight the importance of including ALL populations in the coverage models of the malaria program in order to reach the elimination/eradication goals set out in the malaria strategic plan
4.3.3 Efforts to resolve health system weaknesses and gaps	Humanitarian situations are most likely to interrupt health care infrastructures and delivery of services. In response, humanitarian actors mobilise resources to cover gaps. It must be emphasised, however, that such resources are time limited and not targeted at re-building a complex infrastructure. Gaps will need to be addressed through health system strengthening approaches to re-establish functioning service delivery and care capacities.
4.4 Round 10 Priorities	Ensure that populations affected by humanitarian situations are included in the programmatic analysis and prioritisation process
4.6.2 Links to non-Global Fund sourced support	Ensure linkages with the work of humanitarian actors and other organisations supporting displaced populations, emergency situations and humanitarian needs to show additionality.
4.8.3 Strengthening monitoring and evaluation systems	Humanitarian and emergency monitoring and surveillance systems are available and are most likely in place during humanitarian interventions. Explain how humanitarian partners will contribute to the improvement of the M&E systems in the country to overcome gaps and/or strengthen reporting into the national impact measurement systems framework.
4.9.3 Pre-identified sub-recipients	see 2.2.4
5.1 Financial gap analysis	Include the contributions of other donors and organisations supporting emergency and refugee/displaced programmes
Budget and M&E plan	Ensure that funds in support of humanitarian emergencies and refugees/displaced programmes are clearly identified; including resources requested from the Global Fund as well as external contributions.

Further reading:

Humanitarian response mechanisms:

The Humanitarian Reform Process: Cluster Approach
(<http://www.humanitarianreform.org/>)

Minimum international Standards in disaster response:

The Sphere Project and Handbook (www.sphereproject.org/)

Malaria control in Emergencies

Malaria Control in Complex Emergencies: An Inter-agency Field Handbook
Global Malaria Action Plan, Part IV, Chapter 10: Humanitarian Crisis

PSM

PSM Issues³

The grant process—from proposal development to planning to implementation—should include key stakeholders to promote ownership of the process and minimize opposition. PRs and SRs need to agree on their respective roles and responsibilities and develop mechanisms for collaboration. Appointing PRs with the experience and capacity to implement large projects may limit the time spent on capacity building rather than on the final targets and health outcomes; PRs may consider delegating key responsibilities to expert institutions and decentralizing implementation activities while focusing on overarching activities.

Early planning which may include written documentation outlining activities with timeline estimates, and any needs for external technical assistance may facilitate the implementation process. However, while having detailed written plans is helpful, mechanisms need to be created to ensure that agreed-upon plans are implemented and that commitments are fulfilled. Plans also need to address the coordination of components such as policy changes, procurement, training, and communication to ensure that the preparatory steps are completed before medicines begin to be distributed to the facilities. Systems to ensure quality assurance in supply chain management should be built in early and include mechanisms for monitoring and evaluation. Overall, a clear and logical fit among the grant's targets and milestones, the disbursement of funds, and the planned activities with synchronized timing may help to ensure that funds are available for the activities and facilitate the meeting of the targets.

Effective Coordination among Stakeholders

- Clearly articulated stakeholder roles and responsibilities may lead to smoother implementation
- Memorandums of Understanding (MOUs) or other contractual mechanisms among PRs and SRs may help establish/create greater accountability
- Review of the Global Fund guidelines on country coordinating mechanisms (CCMs) may assist stakeholders to better understand roles and responsibilities
- Incorporating potential stakeholders including those in the private sector early in the process promotes ownership and subsequent acceptance and adherence to the policy
- Creating mechanisms for coordination and collaboration among PR, SR, and other implementers assists the implementation process

³ Adapted from: Shretta, R. 2007. *Global Fund Grants for Malaria: Summary of Lessons Learned in the Implementation of ACTs in Ghana, Nigeria, and Guinea-Bissau*. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health.

- Delegating specific functions while maintaining oversight has the potential to liberate the PR for macro-level activities
- Decentralizing resources for implementation can enable a more rapid implementation process

Principal Recipient Selection

- Selecting PRs on the basis of stricter criteria that measure their capacity and ability may promote great credibility and smoother implementation
- Assuring that PRs have experience and capacity in procurement and supplies management reduces bottlenecks in these processes

Procurement and Distribution Planning

- Developing implementation, procurement, distribution, training, and M&E plans soon after the proposal is approved and before implementation begins may facilitate appropriately planned implementation
- Including provisions for technical assistance and capacity building in key areas ensures budgets are available with minimal time lag for obtaining such assistance
- Clarifying country procurement procedures, preparing needed documents, and budgeting adequately for complementary activities, such as customs clearance and distribution, ensures budgets are available for these activities with minimal lead times
- Involving existing institutions involved in the country's pharmaceutical management, and using the existing distribution agency as a central information system may facilitate adequate buy-in and utilization of existing systems

PSM Plan Development

Plans should carefully developed in collaboration with key stakeholders, including specific timelines with clear-cut roles and responsibilities. In addition, the milestones and targets should be realistic and aligned with fund disbursement.

Procurement

- Understanding the procedures of suppliers, procurement agents, and others involved in the procurement process, including the payment terms may reduce lead times
- Direct disbursement by the Global Fund to the suppliers may reduce procurement lead times

Supply Chain Management

- Distribution is a key area in which countries may be able to take advantage of existing stakeholder technical expertise in the country
- Budgeting accurately the costs of distribution at the onset is beneficial
- Consider how distribution to the lower-levels will occur

- Consider systems created to track inventory or to reorder stock at the state and facility level
- For LLINs, consider routine distribution and replenishment of stocks

Training and Communication

- Coordinating training to begin before medicines arrive in country and end before distribution begins helps minimize time lag for distribution while ensuring effective recall of issues by the health care providers
- Training all health system cadres in key pharmaceutical management functions may improve the supply chain management of the commodities
- Avoiding registering products that do not comply with standard dosage schedules or quality standards may reduce the likelihood of their procurement and wide distribution and prevent adverse drug reactions
- Developing mechanisms to address the quality of the locally produced medicines as part of a broader quality assurance system may facilitate instilling consumer confidence in the new treatment, particularly if it is being manufactured locally.
- Develop a comprehensive training plan (written)

Program Monitoring, Evaluation, and Reporting

- Aligning milestones and targets with activities and fund disbursement facilitates the continuous availability of funds for planned activities
- Developing realistic targets improves the likelihood that targets are effectively met
- Coordinating the system for monitoring for malaria with other diseases may assist in efficient utilization of resources for similar activities and avoids duplication recording
- Recruiting staff to collect and analyze data helps with efficiency and long-term cost effectiveness
- Standardizing reporting systems avoids overburdening the system with multiple streams of data and reporting mechanisms

Voluntary Pooled Procurement (VPP)

The Voluntary Pooled Procurement (VPP) is a Global Fund service created to improve Procurement and Supply Chain delivery of health commodities to Principal Recipients and countries, reduce bottlenecks, increase efficiency, reduce prices, and avoid stock-outs. All Global Fund grants are eligible to access the VPP, and the process is entirely optional to Principal Recipients and countries. VPP can be used for all or a smaller proportion of Global Fund orders in any given country and there are no minimal orders for VPP.

The Global Fund has contracted Procurement Service Agents (PSAs) to facilitate the procurement of LLINs, insecticide retreatment kits, diagnostics tests and ACTs (or other anti-malarial pharmaceuticals) for malaria grants. The PSAs will assist Principal Recipients in procuring and receiving the selected commodities. The PSAs offer a full range of services, including purchasing, quality control, shipping and delivery of commodities to designated delivery points.

There are two delivery options for VPP orders: (a) delivery to a first port of entry or (b) delivery to the state/regional levels. VPP will not deliver beyond state/regional levels. In addition, PRs can request for inspection, sampling and/testing services, coordinating mandatory pre-shipment inspections, assistance with customs clearing and temporary warehousing. Some assistance from the PR may be necessary for obtaining approvals and required documents to facilitate these processes.

The VPP has no pre-negotiated prices for commodities, each tender will be pooled with those of other countries and the PSAs will conduct a competitive procurement process. All LLINs purchased under VPP have to be WHOPEs-Phase II recommended, while selection of ACTs (and other anti-malarial pharmaceuticals) is guided by the Global Fund's Quality Assurance policy for pharmaceutical products. More detailed information can be obtained from:

VPP FAQ: http://www.theglobalfund.org/documents/psm/VPP_CBS_FAQ_en.pdf

VPP standard operating procedures:

http://www.theglobalfund.org/documents/psm/VPP_SOP_en.pdf

Maternal and Child Health

During the 21st Global Fund Board Meeting (28-30th April, 2010) there was a strong recommendation from the board to support the scale up of Maternal & Child Health programming. Specifically the board states that:

- “The Board encourages countries and partners, as a matter of urgency, to work together in the context of opportunities presented through grant reprogramming, Round 10, and changes to the Global Fund grant architecture to urgently scale up investments in MCH in the context of the Global Fund's core mandate.
- Exploring Options for Optimizing Synergies with Maternal and Child Health The Board strongly encourages CCMs to identify opportunities to scale up an integrated health response that includes MCH in their applications for HIV/AIDS, tuberculosis, malaria and HSS.”
- The Board recommendation clearly supports integrated MCH programming, although there is little detail on what can or cannot be funded. Also, the Board stated that any MCH investments should be “In the context of the Global Fund's core mandate”; therefore should be clearly linked to HIV, TB and malaria interventions.

As such, the HWG recommends that CCMs interested in funding integrated approaches through the GF should look at building systems that are clearly linked to the three diseases e.g. community health workers who treat malaria, information systems used by malaria control programmes, training of health workers etc. All such activities, while primarily supported by malaria funding, can be used to address other issues. Community health workers can manage other diseases such as pneumonia or diarrhea, training should not only be malaria specific but can be integrated, and information systems could be integrated to report on multiple diseases. Communication materials, training guidelines and treatment guidelines can also include integrated maternal and child health approaches.

Clearer guidance will be provided at the Mock TRP following further consultations on this issue.

1. Proposal development process planning template :

Activity	Timeline																Responsibility	
	April	May				June				July				August				
		3_7	10_14	17_21	24_28	31_4	7_11	14_18	21_25	28_2	5_9	12_16	19_23	26_30	2_6	9_13		16_20
Review of Programme Needs, decision by CCM to apply for rd 10																		
Agree broad strategic priorities and targets including preliminary gap analysis																		
Establish method of work, designate working groups																		
Define technical assistance requirements including timings																		
Collect relevant background documents/information including gap analysis, partner resource mapping and commodity and service delivery costs																		
Review RBM briefing note																		
Review proposal guidelines and forms																		
Develop outline of proposal contents																		
Presentation to CCM to agree on proposal contents																		
Proposal drafting workshop																		
First draft of proposal																		

Annex:

Malaria Global Fund Proposal Development

**A COMPILATION OF WHO
REFERENCE MATERIAL
May 2010**

Global Malaria Programme



**World Health
Organization**

I. Case Management

1. *Guidelines for the treatment of malaria, 2nd ed.* Geneva, World Health Organization, 2010.

http://whqlibdoc.who.int/publications/2010/9789241547925_eng.pdf

The World Health Organization Guidelines for the treatment of malaria provides evidence-based and up-to-date recommendations for countries on malaria diagnosis and treatment which help countries formulate their policies and strategies. In scope, the Guidelines cover the diagnosis and treatment of uncomplicated and severe malaria caused by all types of malaria, including in special groups (young children, pregnant women, HIV /AIDS), in travellers (from non-malaria endemic regions) and in epidemics and complex emergency situations.

The first edition of the Guidelines for the treatment of malaria were published in 2006. The second edition introduces a new 5th ACT to the four already recommended for the treatment of uncomplicated malaria. Furthermore, the Guidelines recommend a parasitological confirmation of diagnosis in all patients suspected of having malaria before treating. The move towards universal diagnostic testing of malaria is a critical step forward in the fight against malaria as it will allow for the targeted use of ACTs for those who actually have malaria.

2. *Malaria case management: operations manual.* Geneva, World Health Organization, 2009.

http://whqlibdoc.who.int/publications/2009/9789241598088_eng.pdf

The purpose of this manual is to advise those responsible for national malaria control programmes on the best ways of ensuring access to early diagnosis and appropriate, effective case management based on sound practice and WHO's experience in the use of artemisinin-based combination treatment. The manual describes malaria programme management, planning and implementation and outlines the technical knowledge needed for case management. It is intended for adaptation and use in all malaria-endemic countries, irrespective of their epidemiological and socioeconomic specificities.

II: Supply Chain Management

1. *Malaria Microscopy Quality Assurance Manual.* Geneva, World Health Organization, 2009.

http://www.who.int/malaria/publications/malaria_microscopy_QA_manual.pdf

This manual provide a description of the minimal requirements for a malaria microscopy QA programme, which should include the following: 1) a central QA coordinator; 2) a reference (core) group of microscopists; 3) training with competency standards; 4) re-training supported by validated reference slide set; 5) sustainable slide cross-checking system; 6) good supervision; 7) reliable supply management; 8) clear standard operating procedures at all levels; 9) adequate budget. The mode of implementation of the QA system outlined in this manual will vary according to the organization of the national laboratory services dealing with malaria in each country.

2. *Information note on interim selection criteria for procurement of malaria rapid diagnostic tests (RDTs).* Geneva, World Health Organization, 2010.

http://www.who.int/malaria/diagnosis_treatment/diagnosis/infoRDTinterimcriteria.pdf

In view of the increasing demand of countries to scale-up malaria diagnostics following the large-scale introduction of expensive antimalarial medicines, and the decreasing malaria trends in many countries, there is a need to provide clear guidance on the criteria for selecting malaria diagnostics meeting international quality standards. This information note is addressed to managers of national malarial control programmes and other technical experts involved in making decisions for procurement of malaria rapid diagnostic tests (RDTs) and provides recommendations on the key RDT selection criteria.

3. *Malaria Rapid Diagnostic Test Performance Results of WHO product testing of malaria RDTs: Round 1 (2008).* Geneva, World Health Organization, 2009.

<http://www.finddiagnostics.org/export/sites/default/media/press/pdf/Full-report-malaria-RDTs.pdf>

In 2006, WHO and FIND (Foundation for Innovative New Diagnostics) launched an evaluation program to assess the performance of commercially available malaria RDTs and allow direct product comparisons that would assist WHO, other UN agencies and national governments in making procurement decisions and would ultimately encourage improvement in the quality of manufacturing. This report presents an overview of the results of the first round of the WHO product testing of malaria antigen-detecting RDTs completed in 2008. The RDT evaluations summarized here were performed as a collaboration between WHO, TDR, FIND, the US Centers for Disease Control and Prevention (CDC) and other partners. The evaluation is designed to provide comparative data on the performance of the submitted production lots of each product.

4. *Malaria Rapid Diagnostic Test Performance Results of WHO product testing of malaria RDTs: Round 2 (2009).* Geneva, World Health Organization, 2010.

http://whqlibdoc.who.int/publications/2010/9789241599467_eng.pdf

This summary presents an overview of the results of the first and second rounds of WHO product testing of malaria antigen-detecting RDTs completed in 2008 and 2009 respectively, and is published in conjunction with the release of the results of Round 2. The results of the two rounds of testing should be considered as a single data set, and the full reports of both Rounds 1 and 2 consulted for further detail on product performance, and on the interpretation and use of these results.

The RDT evaluations summarized here were performed as a collaboration between WHO, TDR, FIND, the US Centers for Disease Control and Prevention (CDC) and other partners.

The evaluation is designed to provide comparative data on the performance of the submitted production lots of each product.

5. *FIND Malaria RDT product testing interactive guide.* FIND Diagnostics, 2009.

http://www.finddiagnostics.org/programs/malaria/find_activities/product_testing/malaria-rdt-product-testing

This interactive guide is designed to help select malaria RDTs with the specific performance characteristics required by national malaria control programmes, based on the results of the [WHO-FIND malaria RDT product testing programme](#) Round 1 (2008) and Round 2 (2009).

6. *WHO/FIND RDT lot testing programme.* World Health Organization Regional Office for the Western Pacific, 2005.

http://www.wpro.who.int/sites/rdt/who_rdt_evaluation/lot_testing.htm

This document describes the procedures to be followed for testing all lots (batches) of RDTs before deployment to the field. The Lot testing can be done: (1) before purchase, directly arranged with the manufacturer and a lot-testing centre; or (2) after purchase, before distribution to the field (more common). Lot-testing is performed in three centers in Addis Ababa, Manila and Phnom Penh, which are supported through a joint programme of the WHO and the Foundation for Innovative New Diagnostics (FIND). The results are provided to the requisitioner within 5 working days of receipt of the sample at no cost (except for the cost of shipment of the samples to one of the above testing center)

7. *Good procurement practices for artemisinin-based antimalarial medicines.* Geneva, World Health Organization, 2010.

http://whqlibdoc.who.int/publications/2010/9789241598927_eng.pdf

This practical manual guides the selection and procurement of safe and effective artemisinin-based antimalarial medicines meeting international quality standards through a concise 16-step checklist. It aims to improve the capacities of national and international procurement officers in understanding key quality elements and their essential documentation. The manual covers all aspects of the procurement cycle, putting special emphasize on product specifications and the evaluation of product quality.

8. *WHO List of Prequalified Medicinal Products.* World Health Organization, 2010.

<http://apps.who.int/prequal/>.

This regularly updated list contains medicinal products used for HIV/AIDS, tuberculosis, malaria and other diseases, and for reproductive health, which have been assessed as part of the WHO Prequalification Programme and found to be acceptable, in principle, for procurement by UN agencies.

The WHO Prequalification Programme focuses on a selection of products that have been identified by the respective WHO disease departments as essential for treatment of the above-mentioned diseases or for reproductive health (see "Invitations for Expression of Interest"). Prequalification of medicinal products normally involves evaluation of data relating to their quality, safety and efficacy as well as inspection of the relevant manufacturing and clinical site, as described elsewhere in this web site.

Listed are the pharmaceutical products (manufactured at the specified manufacturing sites according to accepted specifications) for which - at the time of assessment - the product data and information submitted were found to meet the norms and standards recommended by WHO and for which - at the time of inspection - the relevant manufacturing and clinical sites were found to be in compliance with Good Manufacturing Practices, Laboratory Practices and Clinical Practices, as applicable. Some of the products have been listed relying on the assessment carried out by certain regulatory authorities, which are willing to share information with WHO (see Alternative listing procedure).

9. *Antimalarial medicines available for procurement by WHO*. World Health Organization, 2010.

<http://www.who.int/malaria/publications/medicines.pdf>

Regularly updated list of antimalarial medicines available for procurement by WHO.

10. *Marketing of oral artemisinin-based monotherapy medicines*. World Health Organization, 2010.

http://www.who.int/malaria/marketing_of_oral_artemisinin_monotherapies/en/index.html

WHO urges regulatory measures to stop marketing of oral artemisinin-based monotherapies and to promote access to artemisinin-based combination therapies (ACTs). This web page provides information on key facts and data on the marketing of oral artemisinin-based monotherapies by manufacturers and the regulatory action taken at country level.

:: [Phasing out oral artemisinin-based monotherapy medicines \[pdf 92kb\]](#)

:: [Marketing of oral artemisinin-based monotherapies - Countries \[pdf 31kb\]](#)

:: [Marketing of oral artemisinin-based monotherapies - Manufacturers \[pdf 33kb\]](#)

11. *World Health Assembly Resolution 60.18, Agenda Item 12.5, Document A60/12*. World Health Organization, 2007.

http://apps.who.int/gb/ebwha/pdf_files/WHA60/A60_R18-en.pdf

WHO urges regulatory measures to stop marketing of oral artemisinin-based monotherapies and to promote access to artemisinin-based combination therapies (ACTs). This page provides the original text of the Resolution 60.18 taken by the World Health Assembly in May 2007.

III. Community Case Management of Malaria

12. **1. *The Roll Back Malaria Strategy for Improving Access to Treatment through Home Management of Malaria*. Geneva, World Health Organization, 2005.**

http://whqlibdoc.who.int/hq/2005/WHO_HTM_MAL_2005.1101.pdf

This publication presents the available evidence, information, experience and best practices relating to the Home Management of Malaria (HMM) (now referred to as Community Case Management of Malaria). It clearly defines the goals, objectives and components of the strategy and outlines the environment that must be developed to enable the various steps of the strategy to be implemented. It is intended to meet the needs of managers of national malaria control programmes within ministries of health, project implementers within communities and policy-makers. The HMM strategy will help to ensure that effective components are implemented to achieve an acceptable nationwide coverage in order to reduce malaria morbidity and mortality in children.

13. **2. *Scaling Up Home-Based Management of Malaria: From Research to Implementation*. Geneva, World Health Organization, 2004.**

http://whqlibdoc.who.int/hq/2004/WHO_HTM_MAL_2004.1096.pdf

The wealth of information on and experience of Home Management of Malaria (HMM) (now referred to as Community Case Management of Malaria) that existed, primarily in research settings and demonstration projects up to January 2002 has been captured in this document. HMM was shown to be both feasible and effective in ensuring prompt access to appropriate treatment in the African region. This document captures the experiences at all stages of scaling up HMM from training of and provision of information to all those involved in the process – from the manufacturer to the caregiver, from the trained health care worker to the volunteer – as well as supervision, monitoring, and evaluation.

IV: Malaria in Pregnancy

1. *A Strategic Framework for Malaria Prevention and Control During Pregnancy in the African Region*. World Health Organization Regional Office for Africa, Brazzaville, 2004.

14. <http://www.afro.who.int/en/divisions-a-programmes/atm/malaria/mal-publications.html>

In Africa, the impact of malaria on pregnant women and children under 5 differ according to transmission and immunity levels. In areas of low or unstable malaria transmission, women have no significant level of immunity and will develop clinical illness when parasitaemic. They are at risk of dying from severe malarial disease or from experiencing spontaneous abortion, premature delivery or stillbirth. In areas of high or moderate (stable) malaria transmission, women are semi-immune, and most malaria infections, although asymptomatic, can contribute to severe maternal anaemia and thus increased risk of maternal death. Malaria infection of the placenta and malaria-caused maternal anaemia contribute to low birth weight, which results in higher infant mortality and impaired child development. This strategic framework for malaria prevention and control during pregnancy in areas of stable malaria transmission recommends three interventions: intermittent preventive treatment (IPT), insecticide-treated nets (ITNs) and case management of malaria illness and anaemia.

15. **2. *Malaria in pregnancy: Guidelines for measuring key monitoring and evaluation indicators.* Geneva, World Health Organization, 2007.**

http://whqlibdoc.who.int/publications/2007/9789241595636_eng.pdf

Effective implementation of the recommended strategy for malaria in pregnancy requires close collaboration between malaria control and reproductive health programmes at all levels, including policy development, planning, logistics, procurement, training and service delivery. Expanding programme coverage will require careful monitoring of implementation and evaluation of impact. To assess progress in and effectiveness of the delivery of interventions for the control of malaria during pregnancy, core indicators of process, outcome and impact have been defined in this document. This document provides guidance to malaria control and reproductive health care workers, particularly those in antenatal care clinics, for monitoring and evaluation of key indicators of malaria in pregnancy.

16. **3. *Technical expert group meeting on intermittent preventive treatment in pregnancy (IPTp).* Geneva, World Health Organization, 2007.**

<http://www.who.int/malaria/publications/atoz/9789241596640/en/index.html>

Intermittent Preventive Treatment in pregnancy (IPTp), a strategy recommended by WHO in 1998, and which is since being scaled up in countries in areas of high malaria transmission. This document summarises the outcomes of a WHO technical meeting on IPTp which addressed the role of sulfadoxine-pyrimethamine and its continued use in the light of increasing parasite resistance to this medicine.

V. Intermittent Preventive Treatment in Infancy (IPTi)

17. **1. *Report of the technical Consultation on Intermittent Preventive Treatment in Infants (IPTi), Technical Expert Group on Preventive Chemotherapy.* Geneva, World Health Organization, 2009.**

<http://www.who.int/malaria/publications/atoz/tegconsultiaptiapr2009report.pdf>

WHO recommends Intermittent Preventive Treatment for infants (IPTi) as additional malaria control strategy in areas of moderate and high malaria transmission. Intermittent Preventive Treatment in Infancy with SP (SP-IPTi) is the administration of a full therapeutic course of SP delivered through the Expanded Program on Immunization (EPI) at defined intervals corresponding to routine vaccination schedules to infants at risk of malaria. This is the report of the expert committee which assessed the evidence on IPTi.

18. **2. *WHO Policy recommendation on Intermittent Preventive Treatment during infancy with sulphadoxine-pyrimethamine (SP-IPTi) for Plasmodium falciparum malaria control in Africa.* Geneva, World Health Organization, 2010.**

http://www.who.int/malaria/news/WHO_policy_recommendation_IPTi_032010.pdf

WHO recommends Intermittent Preventive Treatment for infants (IPTi) as additional malaria control strategy in areas of moderate and high malaria transmission. Intermittent Preventive Treatment in Infancy with SP (SP-IPTi) is the administration of a full therapeutic course of SP delivered through the Expanded Program on Immunization (EPI) at defined intervals corresponding to routine vaccination schedules to infants at risk of malaria.

VI: Monitoring Antimalarial Drug Efficacy

19. **1. *Methods for surveillance of antimalarial drug efficacy.* Geneva, World Health Organization, 2009.**

http://whqlibdoc.who.int/publications/2009/9789241597531_eng.pdf

This protocol has recently been updated in 2009, and now includes protocols for high transmission areas and for low to moderate transmission areas as well as for monitoring the efficacy of antimalarial medicines against vivax malaria. Resistance to antimalarial drugs is a major public health problem, which hinders the control of malaria. In order to combat the growing parasite resistance to medicines, a surveillance system is needed, which will facilitate monitoring of drug efficacy and containment of resistance. The WHO recommended methods for the surveillance of antimalarial drug efficacy have been regularly updated based on changing scientific developments and advancing technical standards. This document provides the latest recommended methodologies for the routine monitoring therapeutic efficacy of antimalarial medicines.

20. **2. *Methods and techniques for clinical trials on antimalarial drug efficacy: genotyping to identify parasite populations.* Geneva, World Health Organization, 2008.**

http://whqlibdoc.who.int/publications/2008/9789241596305_eng.pdf

Standardization of end-points for the purposes of regulatory clinical trials and antimalarial drug monitoring has become widely accepted, driven to a large extent by the WHO Guidelines for the Treatment of Malaria (WHO, 2010). The long follow-up periods of assessment make antimalarial drug efficacy outcomes difficult to interpret, particularly in high-transmission areas, because new *P. falciparum* infections occurring during follow-up can be wrongly interpreted as treatment failures. Therefore, molecular genotyping of parasites is required to distinguish between parasites which recrudesced as a result of drug failure, and those which emerged due to a new infection. This document provides guidance and methodologies for molecular genotyping.

3. **3. *Strategy Paper on Management of Antimalarial Drug Resistance (prepared for the Roll Back Malaria (RBM) Board).* Geneva, World Health Organization, 2009.**

http://rbm.who.int/partnership/wg/wg_management/docs/RBMStrategy_AntimalarialDrugResistance.pdf

Because of the constant battle with drug resistance, which began in the 1960s, WHO has established a strategy for dealing with antimalarial resistance, which has four key elements: 1) Preventing the emergence of antimalarial drug resistance; 2) Monitoring antimalarial drug efficacy, and when necessary confirming drug resistance; 3) Ensuring a continuous pipeline of new antimalarial medicines; 4) Containing the spread of antimalarial drug resistance once it has emerged. This paper sets out how the constituencies and mechanisms of the RBM Partnership can work together to mitigate the risk of emerging drug resistance which potentially undermines progress in malaria control.

VII. Malaria vector control

21. **1. *Long -lasting insecticidal nets for malaria prevention.* Geneva, World Health Organization, 2007.**

<http://www.who.int/malaria/publications/LLINmanual.pdf>

The purpose of this manual is to advise those responsible for malaria control programmes on how to use correctly long-lasting insecticidal nets (LLINs) in order to protect some or all populations at risk. The manual is designed as a practical guide on malaria prevention through the use of insecticide-treated nets (ITNs), particularly long-lasting insecticidal nets (LLINs). Correctly used, LLINs provide protection to individual users. When a high proportion of people sleep under them, LLINs may also have a role in controlling vector mosquitoes, thus reducing transmission and the risk of malaria to other community members.

22. **2. *Insecticide treated mosquito nets: A WHO position statement.* Geneva, World Health Organization, 2007.**

<http://www.who.int/malaria/publications/atoz/itnspopaperfinal.pdf>

This Position Statement from the WHO Global Malaria Programme (WHO/GMP) describes a shift in guidance on malaria prevention through the use of insecticide-treated nets (ITNs). The WHO/GMP calls upon national malaria control programmes and their partners involved in insecticide-treated net interventions to purchase only long-lasting insecticidal nets (LLINs), obviating the need for regular insecticide treatment. LLINs should be distributed free or highly subsidized LLINs, either directly (mass distribution, health facilities) or through voucher/coupon schemes. Communication and advocacy strategies are needed to promote effective use of LLINs and there is need to implement strategies to sustain high levels of LLIN coverage in parallel with strategies for achieving rapid scale-up

23. 3. Use of indoor residual spraying for scaling up global malaria control and elimination. Geneva, World Health Organization, 2006.

http://whqlibdoc.who.int/hq/2006/WHO_HTM_MAL_2006.1112_eng.pdf

Effective implementation of IRS with DDT or other recommended insecticides should be a central part of national malaria control strategies where this intervention is appropriate. It is implemented with the objective of reducing malaria morbidity and mortality and accelerating progress towards global and national malaria targets. However, there are important considerations that must be taken into account when deciding whether to introduce or scale up IRS. This position statement is intended for public health policy makers, malaria control programme managers, development agencies, development banks, academic and research institutions and private sector corporations involved in scaling up malaria control programmes.

4. Malaria vector control and personal protection: report of a WHO study group. (WHO technical report series; no. 936). Geneva, World Health Organization, 2006.

http://whqlibdoc.who.int/trs/WHO_TRS_936_eng.pdf

A report of WHO study group on Malaria Vector Control to address the concern that, despite national and global efforts to control malaria, the disease burden remains high, especially in tropical Africa. The situation being further compounded in emergency situations. The study group reviewed the current vector control strategies and their effectiveness in various operational and eco-epidemiological settings and identified the challenges for implementation in different health systems. This serves as a basis for the development of a strategic framework for strengthening malaria vector control implementation.

5. Technical consultation on combining indoor residual spraying and long-lasting insecticidal net interventions. Geneva, World Health Organization, 2009.

[This document has been finalized and being formatted. It is available on request from the WHO Global Malaria Programme. It will be placed on the following website within the next few weeks.](http://www.who.int/malaria/vector_control/en/)
http://www.who.int/malaria/vector_control/en/

This WHO consultation involving country programs and academic and research institutions, non- governmental organizations and international agencies communicated their experiences of implementing combined interventions. The available scientific evidence and programme field need and experience on combined delivery of IRS and LLINs are presented; research needs and research protocols were formulated, and finally a guidance framework for the combined use of LLIN and IRS is provided.

6. Indoor Residual Spraying (IRS). An Operational manual for indoor residual spraying for malaria transmission control and elimination. Geneva, World Health Organization, 2010.

[This document has been finalized and is being formatted. It is available on request from the WHO Global Malaria Programme. It will be placed on the following website within the next few weeks.](http://www.who.int/malaria/vector_control/en/)
http://www.who.int/malaria/vector_control/en/

The purpose of this IRS manual is to provide the knowledge, standards and step by step guidance on the overall management of an IRS programme, together with practical steps on household spray application, to enable national programmes to develop or refine policies and strategies; develop or update existing guidelines; develop or update training materials; review access and coverage of programmes; review quality and impact of programmes. This manual is divided into three major chapters: 1) IRS policy, strategy and standards for national policy makers and programme managers; 2) IRS management, including stewardship and safe use of insecticides, for both national programme managers and district IRS coordinators; 3) IRS spray application guidelines, mainly for district IRS coordinators, supervisors and team leaders. National orientation, adaptation, training and translation of the manual to appropriate languages are highly recommended for its optimal use.

VIII: Surveillance, Monitoring and Evaluation for high-burden Countries

24. **1. Chapter 2. Policies, strategies and targets for malaria control. In: *World malaria report 2009*. Geneva, World Health Organization, 2009.**

http://whqlibdoc.who.int/publications/2009/9789241563901_eng.pdf

Chapter 2 describes 13 indicators recommended by WHO for regular monitoring of malaria control programs that can be derived from routine information systems (including surveillance of cases and deaths, monitoring program coverage and quality). Four indicators that can be monitored from household surveys are also highlighted. The chapter also lists the internationally agreed targets for malaria control programs linked to these indicators.

IX. Malaria Elimination

25. **1. *Malaria elimination - a field manual for low and moderate endemic areas*. Geneva, World Health Organization, 2007.**

http://whqlibdoc.who.int/publications/2007/9789241596084_eng.pdf

This manual is intended to inform national governments from endemic countries, partner and donor agencies and field managers about the issues related to malaria elimination.

Malaria elimination – the interruption of local mosquito-borne malaria transmission – is the end goal in the fight against the disease. This manual has been developed to provide guidance to the increasing number of countries that have decided to eliminate malaria from their territory.

An elimination programme builds on the successful control of malaria mortality and morbidity. The evolution of the programme, from control to elimination to preventing re-establishment of malaria, is described in detail, along with the important programme reorientations. Drawing on recent experience from various countries with malarious areas, the feasibility of malaria elimination is discussed, helping countries to set realistic targets and timescales. Descriptions are provided of tools and approaches that are specific or particularly relevant to elimination: case detection, prevention of onward transmission, and management of malaria foci and of importation of malaria parasites. As monitoring and evaluation are essential components of the programme, recommended indicators, data sources and methodologies are outlined. Monitoring and evaluation not only allow the progress of the programme to be assessed and documented, but also allow a credible information database to be established, which is needed for ultimate certification of malaria elimination. Certification of malaria elimination – the recognition of a considerable operational achievement – is granted by the World Health Organization to countries that have successfully maintained their malaria-free status for at least three consecutive years. Requirements and procedures for certification are described, along with details of the follow-up of certification.

26. **2. *Global malaria control and elimination: report of a technical review*. Geneva, World Health Organization, 2008.**

http://whqlibdoc.who.int/publications/2008/9789241596756_eng.pdf

Several countries, including those in high transmission areas of the world, have recently achieved significant success in the control of malaria, reducing the burden of disease and death, and some, achieving a high degree of reduction in transmission. These achievements and experiences of the past few years have inspired the governments of malaria-endemic countries and major international donors to undertake a more ambitious and accelerated effort, to interrupt transmission. This document summarizes the outcomes of a WHO technical meeting of experts which addressed the feasibility of malaria elimination, in relation to the intensity of transmission and vectorial capacity. And WHO recommendations on:

- the directions and approaches that countries should take in each epidemiological situation and transmission intensity, when the disease burden has been decreased at the end of an intensified phase of malaria control over the past few years;
- the feasibility of malaria eradication, given the tools available today and the epidemiology of malaria in various regions of the world; and
- the gaps in knowledge and priorities for research and development in the next phase of malaria control.

27. **3. Chapter 5: Elimination of malaria. In: *World malaria report 2009*. Geneva, World Health Organization, 2009.**

http://whqlibdoc.who.int/publications/2009/9789241563901_eng.pdf.

This chapter of the latest World Malaria Report (2009) describes the state of malaria elimination in the world, to illustrate progress towards the elimination targets. It provides a summary of the progress being made in countries that have embarked on eliminating malaria, including their progression through the different phases from pre-elimination to certification of elimination by WHO. The chapter also provides a brief background to the WHO strategies and guidelines on elimination, as well as a historical perspective of malaria elimination in these countries.

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A COMPILATION OF TRP COMMENTS TO GUIDE THE DEVELOPMENT OF ROUND 10
PROPOSALS: Kwame Agyarko

2010

1. Executive Summary.

The review of TRP feedback to countries has revealed a good understanding of the key issues that the august group of technical panelists base their proposals rating decisions on. It does appear that, the strength of proposals include situations where a good description is provided of the process by which the proposal was developed, the TRP values consultative proposal development processes that includes key stakeholders from all sectors, public, private and civil society. Value is placed on showing clear linkages with existing GF grants, providing sound and feasible technical interventions which are consistent with the national strategic plan and in line with regional and global disease control targets and best practices. In doing this, a good epidemiological description, supported by a well-documented program analysis is needed. Coherency, clear Logic, sound analysis, well articulated goals specific objectives and a good description of the interventions; beneficiaries and the sustainability are the key assets to the overall likability of the process.

On disease control, a theme that is picked up as positive relates to innovative approaches, provision of linkages to other grants, in cases where an intervention is being introduced for a first time, piloting and making clear that lessons will be learnt in a phased implementation approach re all good score points. Concerns include poor quantification, (over or under) of ACTs and RDTs, as related to observed changes in epidemiology or disease burden. For example, the quantification of drug procurement based solely on estimates of incidence without consideration of systems and capacities is seen as inappropriate, in equal measure, estimates for commodities must take into consideration the expected drop in malaria incidence following preventive interventions.

An important part of the proposal is the section on budgets. In the worst rated proposals, the TRP usually states that, there are discrepancies in the budget, financial gap analysis are poorly done, there are a lack of details, and in some cases unit costs are over and above standard known costs, these are all issues that go to question the credibility of the proposal. Inconsistency in calculations, inflated costs, lump sum figures not well explained and poor budgeting do not receive good reviews from the TRP. Clarity, good budget notes, good estimates, detailed break down of costs and assumptions and sound believable justifications earns more positive assessments.

On vector control, a good start is to have a good malaria epidemiological stratification of the country or region, with clear demarcation of where the different vectors control strategies would be deployed, in situations where this is the case. It helps to have in place initiatives to evaluate the potential impact of insecticide(s) on the environment and to monitor the dynamic of insecticide resistance. In cases where IRS and LLINs are proposed as joint and or concurrent interventions, clarity is needed to explain the added advantage of one and then the other, if applied in same locations. Positive remarks are made in cases where such dual interventions follow WHO guidance. On LLINs, quantification, good definition of target population, and distribution methodology are all issues that when not well articulated tend to contribute to poor proposal ratings.

With regards to BCC/IEC, the perennial issue relates to the provision of evidence of the effectiveness of the intervention. Over and above this, positives reviews include sound and evidence based activities, integrated strategies, which demonstrate the intended impact on the population, with strong qualitative and quantitative evidence of impact. It does help to show the involvement of and ownership of communities, civil society organizations and linkages with previous BCC/IEC activities in previous grants.

The review looked at the TRP feedback on alignment of proposals to the national strategy and policy orientations, as well as the nature and strength of national M&E systems, the specific proposal indicators and the M&E platform related to the proposal. Proposals need to have well articulated activities and sound measurable indicators building on a comprehensive implementation strategy rooted in a well-developed national M&E plan and framework. Objectives, service delivery areas and indicators should, in keeping with the focus of the proposal also ensure that they are aligned to the broad national strategic orientation, and contribute to this as well as answering to the specific needs of the proposal. It helps to analyze the strengths and weaknesses of the national system and devise ways to strengthen the M&E system to benefit the data quality and timeliness of reporting. A good understanding of the different levels of indicator formulation and measurement (input, process, output and impact) are an asset. The establishment of baselines and how indicators will be assessed and measured are necessary. Care must be taken to streamline and coordinate to benefit from planned surveys and studies.

Of equal importance is a need to clarify the procurement system in place and proposed. The proper quantification of needs with realistic values is important; focus must be placed on a good description of the procurement arrangements, its strengths and weaknesses. In cases where inherent and persistent PSM weaknesses are the order of the day, the TRP sees value in opting for the GF's Voluntary pooled procurement system.

A key area of interest is the management and implementation arrangements that are proposed to manage the proposal. Here a good description of the implementation arrangements, the coordination mechanism, and the overall impact or effect of the existing health systems is necessary. In cases where previous grants have been awarded, a history of the implementation arrangements, lessons learned and any modifications are also important to make. The selection of principal and sub-recipients must show transparency and cross sectional representation, from Government, faith-based, civil society and the private sector where applicable. The proposal's chances are enhanced when there is clarity in the responsibilities and activities of the key implementers capacity to deliver. The national architectural platform for programme implementation, such as SWAPs and others must be highlighted, especially where that implementation arrangement will affect the proposal. A history of previous grants, AND their performance must also be articulated, more importantly, in cases where it is envisaged that the current proposal may be merged with existing grants, this must be highlighted.

2. Introduction.

The aim of this paper is to provide some examples of the pertinent issues that have been raised by the TRP on submitted proposals. The analysis focuses on recent R9 applications for malaria. The information is gathered from TRP feedback to 19 countries. The comments have been arranged in sub sections, which highlight issues on General presentation and quality of proposal, and specific interventions areas comments on case management, IRS, LLINs, IPT, as well as programme design and management, M&E procurement. Within these three broad sections, each is further sub divided into three key parts, a section on strengths, Weaknesses and Recommendations. It is hoped that this will give proposal developing teams the opportunity to focus on specific issues, identify what the TRP commonly see strengths and weaknesses, in so doing improve the quality of country proposal with the TRP recommendations in mind.

3. Section 1. General presentation and quality of proposal

1.1 Strengths

- **Consultative proposal development process:** The process of proposal development was consultative with key stakeholders including the public sector ministries, civil society organizations, partners, private sector and implementers. There is a thorough description of the proposal development process and consulting with country and regional partners.
- **Clear linkages with exiting grants.** The proposed interventions are logical and technically sound and constitute an expansion and scale-up of grants from previous grants. Complementarily and linkage with other Global Fund grants and other programs supported by Global Fund partners are documented.
- **Interventions are technically sound and feasible and consistent with international best practice:** The proposal is sufficiently detailed and the interventions proposed are technically sound and feasible, with a strong potential for sustainability due to projected efficacy of the interventions. The proposal presents a clear and coherent strategy for scaling up malaria control using an approach that is in line with internationally agreed standards of good practice. Proposal builds on operational research to provide scientific evidence for decision making and further strategy improvements
- **Good supporting documentation:** Supporting documents provided include the national malaria control strategy as well as a recent program evaluation.
- **The proposal takes into account the epidemiological situation of malaria of the country.** Provides a good epidemiological description (and map) of malaria in the country showing distinct malaria epidemiological stratification/zones and how different interventions are targeted to different zones.
- The **analysis of social and gender** equality and the strategy on how to address equality issues are well developed.

- **Good description of community-tailored activities** to promote the use of ITNs, treatment-seeking behaviour, and MiP programmes with a range of IEC/BCC activities to be implemented following pre-testing.
- **Sustainability** addressed through the emphasis on bridging the gap between the nearest health facility and the community via community structures and APEs by developing APE skills and supervision, to encourage prevention and treatment-seeking behavior, treat uncomplicated malaria, and bolster the referral system for those with severe malaria and other diseases.

1.2 Major Weaknesses

In the area of weaknesses, the TRP provides 2 categories, Major and Minor weaknesses, a detailed separation has been made of these, major weaknesses followed by the minor in *italics*.

- **The previous proposal has not been signed which makes assessment of implementation feasibility of such an additional large grant not possible.** Since the links between the Round 8 and 9 are not detailed, there is great potential for duplication and this cannot be assessed with the narrative and work plan provided. Although linkages between previous GF grants and the focus of this proposal are explained, the general description made does not permit to identify the required complementarities.
- The **analysis of major program constraints lacks critical details** about causes of limited program performance. It is stated for example that “lack of local social mobilization resulted in the population not being well informed” yet no explanation is provided on why the previous social mobilization efforts have failed.
- Although the country has **five different zones in terms of malaria epidemiology**, which are all described in the proposal, there is **no differentiation in the programmatic approaches** proposed for each zone.
- **The goals and objectives are not very specific** and do not have clear time bound measurable targets. For example, what is the desired reduction of morbidity and mortality?
- Since the implementation of the Round 6 grant only started recently (see disbursement status), it is not clear whether, where and how a number of activities will complement the ongoing activities or activities which still have to be started up under the Round 6 grant. Although an effort has been made to explain how the Round 6 grant and the Round 9 proposal are linked, a number of questions remain about possible overlaps in areas which include distribution of LLINs, training, communication plan, and monitoring and evaluation.

1.2 a Minor weaknesses

- *The proposal is not very coherent, and there are inconsistencies between descriptive text and tables.*
- *There is a complete disregard for the instructions provided to complete the application regarding page limits, If the proposal complements the Round X grant, it is unclear why the level of support requested for technical assistance (TA) and trainings is needed.*

4. Section 2. Budgeting and Finance

2.1 Strengths

- **The proposal's financial gap analysis, budget, and work plan have no major concerns.** The proposal has clear objectives and appropriate activities for the local context in line with the national plan and evidence-based strategies. The link with previous grants is well described and the proposal builds on previous achievements. There is a very precise needs assessment. The budget of the proposal is clear. Lessons learned from the previous grants have been drawn and improvement has been planned.
- **Excellent programmatic needs assessment** (LLINs, ACTs, RDTs and SP). Malaria **programmatic gaps** and health systems constraints are **identified and possible remedial actions are proposed**.

2.2 Weaknesses

- There are **discrepancies in the budget** that question the credibility of the whole process and **numerous unit costs are largely overestimated**.
- Links to non-Global Fund sourced support are not clearly explained. Allocated figures are mentioned, however the numbers of health services and population covered are not provided.
- A review of the budget resulted in a few minor observations:
 - **lack of detail** on some unit costs (such as quantification of RDTs);
 - There seems to be a range of supervisory visits for different purposes budgeted for, which suggest options for economy.
 - There is a plan to recruit a firm to produce audio and video spots on malaria however **no evidence as to its reasonableness** is provided.
 - There is a plan to support 225 peer health educators (PHEs) with laboratory equipment and consumables. A **breakdown** of this line as well as unit cost per nature of consumable **should be provided**.
 - A **MIS is planned** for Year 2 **but no breakdown** of this amount has been provided.
- Every year, the CCM proposes to **organize technical and administrative inspection** visits to the staff at all levels, **however the assumptions are not explained**.
- The **financial gap analysis assumes that all domestic and external financing of the National Malaria Strategy will gradually cease and that by 2013 the Global Fund Round 9 grant will fund 100% of the strategy**.
- **There are several problems with the presentation of the financial gap analysis.** The financial gap analysis and the supporting text present some errors:
 - The values in table and text do not correspond ,
 - There is no description as to how Global Fund funding will be additional.
 - There are **major budget concerns** that need to be critically reviewed (e.g., storage and distribution costs that are 60 percent of LLIN costs; cost of pumps; multiple costs for transport of commodities).
 - There is an inconsistency in the calculation of needs between the text and the tables; as a result there are discrepancies in the budget that call into question the credibility of the whole process.
 - Communication plan, no rationale or justification is given in the proposal or in budget as to the determination of the item.
 - Salaries included are not justified
 - A lump sum budget to professional fees and fixed fees with no details and no justification; also details on the implementation of the NMCP's monitoring and evaluation plan are missing.
- **Budgetary provision is not made for ACTs and RDTs after the initial supply.** ACTs and RDTs supply for the Home Care program are expected to come from the Rounds 4 and 7 until 2012 when the State and partners are expected to provide ACTs and RDTs. Proposal has no budgetary provision by the State and partners to cover the purchase of ACTs and RDTs after 2012.

2.2a Budgeting and Finance Minor weaknesses

- *Budget for purchase of equipment for IRS is **lumped together** – not enough detail on the equipment to be procured.*
- *Some **budget lines under Objective 3** would have to be justified or explained in more detail if this proposal were to be resubmitted.*
- ***Unit cost for LLITNs varies** from US\$ 8 (Years 2 and 5) to US\$ 7 in Year 3 but no justification is given for the fluctuation and operating costs for PR and SRs is not provided.*
- *There are a number of budget issues related to inflated unit costs. These include the **unit cost of SP, diesel fuel, motor bikes and computers. This appears to be an excessive number of luxury vehicles.***

Recommendations

- Please **review the unit costs** for LLITNs and reduce the budget accordingly.
- **Estimates for commodities** (RDTs) in table 4.4 need to be revised in light of the proposed preventive intervention and also the consolidated Round 2 and 7 Global Fund grants. **Please adjust the budget accordingly.**
- **Provided a detailed breakdown** of the estimated costs of IRS with a determination of the cost per house and per person protected.
- **Please provide a more detailed list of assumptions** used in generative table 4.4 with the model used to calculate the commodities needs of Round 9.
- Please clarify what is in a “unit” of protective equipment as well as the number of each item.
- **The renovation of the premises** of the National Malaria Control Program (NMCP). **No breakdown** of the NMCP rehabilitation budget is provided; this amount **seems very high.**

5. Section 3: Case Management

6. 3.1 Strengths

- **Innovative approach** of using Home Care providers to provide much needed services to populations living in areas without health facilities.
- The **proposal provides linkages** to the ongoing Global Fund grants
- **Piloting** of initiatives such as **Home Care and IRS** in a few districts to first learn and gain experience **before proposing expansion** to national scale.

3.2 weaknesses

- **Laboratory staff previously trained** in the application of RDT and currently available to be trained in orientations to prescribers on diagnostic test compliance and in quality control and assurance, including both sectors (public and private) **is not detailed.**
- While massive **ACT distribution** is planned, and previous Rounds have established a distribution scheme, a brief **description of the current system is not provided.**
- **Poor availability of ACTs** is given as one of the program constraints and the Round 6 proposal was designed to address this problem. **The CCM did not provide clear information about the existing shortage.**
- **Artemether-Lumefantrine** is listed as a second line drug in the proposal, and the quantity for procurement is quite large. It is not clear how this drug will be used in conjunction with the first-line drug Artesunate-Amodiaquine.
- **Estimates for commodities (RDTs) do not take into consideration the expected drop in malaria incidence following preventive intervention.**
- There are **major problems in the quantification of drugs**, bed-nets and insecticides.
- A **quantification of drug procurement** based solely on estimates of incidence without consideration of system and capacities is not appropriate.

3.2a Minor weaknesses

- *Although the proposal states that there will be a decreasing demand for anti-malarial drugs as the prevention program is rolled out, it is impossible to see this in the budget or in Attachment B.*
- **Charging for ACTs and RDTs at community level could result in decreased utilization** by communities but also could be a pervasive incentive for the providers. Payment to Home care providers, other than the sale of ACTs, is not provided.

3.3 Recommendations

- Poor availability of ACTs is also given as one of the program constraints and the Round 6 proposal was designed to address this problem. Please provide a detailed explanation of the how the ACTs from the Round 6 grant were used.
- Please clarify whether there is feasibility information about the wide scale use of RDTs through HMM.
- Number of fever cases tested with RDTs and number of positive RDTs treated with ACTs should be disaggregated by ASHA, public facilities and private providers;

7. Section 4. Prevention- IRS and LLINs (Vector Control)

4.1 Strengths

- **Very good malaria epidemiological stratification** with a clear demarcation of where the different vector control strategies will be deployed.
- There are initiatives under way to **evaluate the potential impact of insecticide on the environment** and to monitor dynamic of insecticide resistance. There is **recognition of the challenge of insecticide and drug resistance** by developing a monitoring system.
- **Phased implementation of IRS in the targeted 16 health districts is well designed.**
- **Switch from targeted LLIN coverage** of pregnant women and children under five (U5s) to **universal coverage** using antenatal clinics (ANCs) and campaigns with experience gained through trials in 2009.
- Consideration is given to **integrating LLIN campaigns with other health activities** (i.e., de-worming, to be discussed on a province by province basis).
- **Clear description of geographic implementation of LLINs to rural areas** (60 percent of the population) and IRS in urban/peri-urban areas (40 percent of the population) – emphasis is not on expansion of coverage, but rather on consolidation and improving the quality of spraying (coverage>80%) with the placement of provincial malaria managers in each province to improve monitoring and evaluation and IRS quality.
- The plan to conduct target use of indoor residual spraying (IRS) (with heavily indebted poor countries (HIPC) funding) and LLINs in limited areas is **consistent with current WHO guidance** to generate the evidence base to support the combined strategy.
- **Strategies for LLITN distribution** in the most remote areas with eventual replacement of indoor residual spraying (IRS) with LLITNs and eventual replacement of the retreatment of conventional nets in the short-term where LLITNs is **appropriate.**
- **Wealth of experience** in community Insecticide Treated Mosquito Nets (ITN) distribution and Indoor Residual Spraying (IRS). They have **demonstrated** proven experience in previous mass campaigns.

4.2 Weaknesses

- **There is no plan to implement a second mass campaign** three years after the first one performed in 2010. **A detailed plan is not provided** to address how the CCM will ensure that the mass distribution of LLITNs is considered beyond 2010.
- The TRP would also like **more information on the assumptions** used to determine the figures budgeted.
- The **feasibility of attaining universal coverage** of LLINs with the present distribution **strategies is not realistic** given that the present LLIN coverage is 34 percent.

- The **proposal details distribution of free LLINs to children** under five years and proposes a campaign in Year 3 to distribute LLINs to children **but doesn't explain how LLINs will be distributed to the adult population.**
- Other than stating that consideration is being given for provision of free LLINs to pregnant women, **descriptions of the present distribution system to adults is limited.** If the present system is not augmented with other systems, the target coverage is not felt to be feasible.
- While both IRS and LLINs have been demonstrated to be effective in preventing malaria, **evidence for the added protective effect of universal concurrent coverage of LLINs and IRS in the epidemiological situation of the country is not provided.** Such evidence should show a significant additional impact on reducing malaria cases where universal IRS and LLIN coverage is attained over areas with only universal coverage with LLINs or IRS. Hence, the concurrent use of IRS and ITNs in the same districts has not been documented as a cost effective intervention.
- The TRP is **concerned about the feasibility of LLIN** distribution through ANCs **which have not performed well under the Round 2 grant** – it has only reached 25 percent of the target of Round 2 and 25 percent in period 3 of the Round 6. These grants targeted pregnant women and children while this Round 9 application will continue to use ANCs in both sprayed and unsprayed areas but will also undertake campaigns in non-IRS areas to seek universal coverage. Under lessons learned, it states “Ministry of Health can manage ANC distributions well, though LLIN distribution supervision should be more integrated with other supervision activities and distribution reporting should be integrated in the Health Information System (HIS)”, but the evidence for this statement is unclear.
- The complimentary vector interventions (LLINs and IRS) are the major drivers of the budget and the objective should be to target either of them and have adequate coverage for one or the other.
- **Only one mass distribution of LLINs is planned. The plan to sustain universal access is not described and is likely to have huge budgetary implications.**
- There is **no demonstrated evidence of the added benefit** (malaria reduction) of expanding IRS to all districts, which are already under universal coverage of LLINs. Given the high cost of such an intervention, strong country-specific evidence of good value for money should have been provided to justify the implementation of a countrywide blanket of IRS.
- The **added value of IRS with LLINs has not been established.** There is a need to disaggregate LLINs and IRS together versus LLINs alone in the three regions to enable an evaluation of integrating these two strategies

4.2a Minor Weaknesses

- *The basis for the costs of LLIN distribution through ANCs and campaigns are not provided. Both distribution mechanisms are budgeted at US\$1.12. Other studies have found campaigns to be significantly less expensive per net distributed than ANC distribution.*
- *The precise number of target population living in high-risk districts is not clear. The target for estimation of LLIN needs is the whole country population (X million people), but the proposal narrative states that the focus will be on high risk districts Recommendations Prevention- IRS and LLINs (Vector Control).*
- *Only one mass distribution of LLINs is planned. Please provide information about the plan to sustain universal access through a second mass distribution and a convincing resource mobilization plan to cover this major gap .*
- *Provide a plan for complementary interventions (Vitamin A, de-worming and/or vaccination, etc.) during mass distribution.*
- *Please provide the populations at risk for each of the eco-epidemiological stratifications*
- *Please clarify the incentive schemes for community workers ensuring that they are aligned with other community initiatives so as not to disrupt these other initiatives.*
- *The added value of IRS with LLINs has not been established. Please disaggregate data on impact of LLINs and IRS together vs. LLINs alone in the three regions to enable an evaluation of integrating these two strategies.*

- *As the Grant Performance Scorecards indicates the applicant has had limited success in distributing LLINs through ANCs (approx 25 percent of the target), please document the justification for the statement “Ministry of Health can manage ANC distributions well”*
- *Provide a breakdown on distribution costs for LLINs associated with ANCs and campaign based distribution systems.*

8. Section 5: BCC- IEC

5.1 Strengths

- **There is an evidence-based, integrated BCC strategy for treatment and prevention**, including monitoring the impact of BCC on the target population and it is a significant revision compared to the fragmented approach that was presented in the Rolling Continuation Channel Wave 5 which was not recommended for funding (Category 3A).
- **The proposal uses community volunteers for Behavior Change Communication (BCC) which is known to be very cost effective.**
- **Behavior Change Communication (BCC) strategy is appropriately based on qualitative and quantitative data.**
- **The plans for Behavior Change Communication (BCC) are well thought through and are based on an assessment of past lessons and critical behavior gaps.**
- **Comprehensive BCC activities are described, including development**, refinement and the delivery of messages with an analysis of the effectiveness of community outreach with reinforcement through radio mass messaging.
- **Engagement with local NGOs and civil society organizations (CSOs), including BCC activities.**

5.2 Weaknesses

- **The BCC interventions funded by the previous grants from the Global Fund have been under-performing and the justification for inclusion of the same interventions is not provided.**
- The activities in the different service delivery areas (except those for BCC) are not focused and do not have performance indicators. Consequently, measuring progress of proposed interventions will prove problematic.

5.3 Recommendation

Provide local evidence (if possible) for effectiveness of the BCC interventions planned.

- Please justify whether television spots have good coverage. **The BCC interventions funded by the previous grants from the Global Fund have been under-performing.** The **justification for inclusion** of the same interventions is needed given the amount of budget allocated to this intervention and research evidence to justify the package of interventions proposed.

9. Section 6: National Strategic alignment, M&E, indicators and systems development

6.1: Strengths

- **Comprehensive implementation strategy** (i.e. the strategic and cross-cutting service delivery areas (SDAs), activities and their indicators) **are well articulated.**
- Proposed **strategies are based in line with the National Health Policy** and current National Malaria Strategic Plan and include all relevant interventions to further reduce the malaria burden.
- **The proposal comprehensively describes the objectives and details the SDAs** and respective activities, which are well linked and aligned with the objectives. The activity plan is based on documented local evidence and takes into account lessons learned from the past and evidence from operational research.
- **Performance framework has clear indicators and realistic targets provided.**
- **Good description of monitoring and evaluation systems utilizing different data platforms including:** MICS, MIS and DHS with routine reporting systems.

- **Good malaria performance framework** with numerous indicators that have baseline values.
- Malaria and health systems gaps are clearly described and potential solutions are stated.
- Goals, objectives, SDAs and activities are very clearly stated with measurable indicators most of which are output or higher level indicators with clear time-bound targets.
- The implementation strategy is very comprehensive, including monitoring and evaluation (M&E), disease surveillance, operations research, drug efficacy and insecticide resistance monitoring as well as risk management strategy for indoor residual spraying (IRS).

6.2 Weaknesses

- The **analysis of factors leading to the poor outcome** of some of the indicators covered by Round X, Y and X is **very weak** and lacks convincing evidence. A detailed strategic plan is not provided to address how the CCM will ensure that targets for a number of indicators are feasible.
- **The proposal does not presents an adequate Monitoring and Evaluation system**, the performance framework lacks impact indicators and service delivery indicators have been misunderstood: they should be more detailed than the outcome indicators.
- **Impact measurement is not well described.** The vision of a “malaria free country” requires a robust system for tracking population and facility based data, including parasite and anemia prevalence, coverage of interventions, malaria case load at health facilities as well as commodity stocks. The plans for strengthening these different data platforms are not well articulated.
- **The SDAs, activities and indicators are not coherent and reflect** the applicant’s misunderstanding about what is implied by service delivery areas in the Global Fund proposals.
- **Attachment A has numerous unclear and inappropriate indicators and targets**, including the following:
 - ✓ There are no baseline values for any indicators;
 - ✓ Many indicators are described as numbers, but targets are expressed as percentages, and it is unclear what the denominators are;

6.2a Minor weaknesses

- *Indicators do not always reflect the priorities/major activities of the proposal.*
- *The baseline values are missing in the performance framework.*
- *No indicators addressing quality of IEC/BCC efforts (measures of changes in knowledge).*
- *Most of the targets of impact and outcome indicator are over-ambitious considering the implementation environment.*
- *The indicators do not adequately measure levels of community involvement or the actions or behaviour change that result (e.g. from activities of the APEs and community structures).*
- *Under diagnosis, the indicator is “Number of health workers trained in laboratory diagnosis of malaria (microscopy and RDT) rather than an indicator for staff performance when using the tests and a quality control (QC) and quality assurance (QA) indicator for RDT use with microscopy as the gold standard.*
- *More indicators are needed for APE activities (proportion of cases correctly diagnosed and treated by APEs or proportion of malaria cases diagnosed and treated by APEs*
- *Also the emphasis on quality of IRS is not addressed in the indicators.*
 - *For example, indicators such as “proportion of houses targeted for spraying that were sprayed prior to the start of the transmission season.*

- *The Monitoring and Evaluation (M&E) plan needs a more detailed process description*
- *There is no precise detail of how impact indicators will be assessed.*

6.3 Recommendations

- **Provide a more precise description of the M&E plan, including how impact indicators will be assessed.** Currently, one of the main impact indicators is malaria-specific and all cause under-five mortality expressed as “82/100,000”; however, the text implies that it will be measured using health center data only. A more precise measurement would include a population survey. On page 10/54, it is mentioned that other donors will provide 500,000 nets but these are not included in the gap analysis table. Please insert them and adjust the budget and total number of nets accordingly.
- **Please include the baseline values**, which are missing in performance framework/program indicators.
- **Output indicators do not address the quality** of services provided. Please include quality of care indicator.
- **Please ensure that the indicators reflect the move to universal coverage** as opposed to the targeted coverage of pregnant women and children under five.
- Attachment A needs to be **adjusted to align indicators and targets** to the priorities and activities. The TRP suggests that consideration of the following points be made in the **adjustment of the performance framework**:
 - ✓ **Number of LLINs distributed should be recorded for each distribution method employed.**
 - ✓ **No BCC indicators related to quality** (i.e. addressing if knowledge is gained or behavior changed); and
 - ✓ **There are no indicators for the sentinel sites** for providing trends in incidence of severe malaria and mortality.
- The CCM must address the following weaknesses:
 - **The analysis of factors leading to poor outcome of some of the outcome indicators** covered by Round X, Y, X grants is very weak and lacks convincing evidence that additional support would generate better results. **A careful analysis of problems that lead to poor outcome indicators, despite the massive infusion of GF resources, should be provided** (e.g. 5.8 percent of children under 5 years of age, who had suffered from uncomplicated malaria within the last 2 weeks, underwent anti-malaria treatment within 24 hours in accordance with national guidelines).

10. Section 7: Procurement

7.1 Strengths

- The **procurement and supply management system** used under Rounds 3, 4, and 6 has **improved substantially**.
- Plans to make **use of the Global Fund’s direct payment facility** and to investigate signing up to the Voluntary Pooled Procurement (VPP) due to limitations in past LLIN procurements.
- **Switch to diagnosis dependent treatment** with emphasis on the role of APEs in delivering diagnosis and treatment close to homes.
- **Well-functioning central medical stores** with established inventory management for ITNs. Lessons learned are incorporated in the design of the present proposal including challenges on the logistics of distribution.
- **The quantification of needs is done well** and assumptions for such quantification are realistic.

7.2 Weaknesses

- Procurement and Supply Management (PSM) costs represents 34 percent of the purchase price of health products; 10 percent is accepted generally.

7.3 Recommendations

None

11. Section 8: Implementation and Management arrangements

8.1 Strengths

- **The plans to reinforce management capacity and coordination mechanism are well described. There is a good description of the weaknesses** of the implementation strategy in the targeted districts. There is evidence of strong coordination at all levels.
- **There is a good analysis of malaria program constraints and gaps.** The health system weaknesses and potential solutions are described well (e.g. policy and leadership, national health service delivery system, health management information system, financing, laboratory services, procurement and supply chain management, and human resources).
- The **proposed strategies to be implemented are consistent with best practices** and gives due priority to groups and communities most vulnerable and affected by malaria.
- **Involvement of community-based health care workers in areas with limited access involved** in the provision of integrated management of childhood illnesses.
- **There is a good history of the implementation of interventions** and the overall impact evaluation.
- **Transparent selection of governmental and faith based sub-recipients** for the different activities is planned.
- The strategy **focus on strengthening health sector and community levels** for malaria management, training health workers and population awareness on prompt malaria treatment.
- The **implementation of the proposal intends to involve a wide range of partners** such as public services and other sectors including the private sector, NGOs, and communities in its implementation, particularly in respect to the behavioral change part.
- The proposal **seeks to identify, train and accredit small private drugs** dispensaries) in an ambition to increase malaria treatment outlets which are heavily used by the public.
- The **constraints and weaknesses of the health system are clearly explained** as well as how they affect the malaria program and how the health systems policies are addressing them.
- **Partnership with NGOs and Civil Society Organizations (CSOs) in delivering community based** malaria interventions. Through contractual agreements, all community-based organizations (faith-based, women, young people, traditional healers etc) have been involved in the malaria prevention and control activities especially Behavior Change Communication/Information, Education and Communication (BCC/IEC) interventions.
- **Clear description of activities/responsibilities** of the PRs and SRs with SR selected through public tender
- **Strong Sector-Wide Approach (SWAp)** mechanism that brings together all development partners.
- There is a **well established interagency coordination committee** and strengthened management through the setting up of a Global Fund unit.
- **Nominating a second Principle Recipient from civil society is to be commended.** There is a active involvement of the private sector. Involvement of the private sector in RDT distribution and ACT treatment with the inclusion of data from the private sector into monitoring and evaluation (M&E).
- **Good complementarity between the Round X grant and World Bank funding.** The proposal focuses on the provision of services to remote minority populations with sufficient attention to gender issues.
- **The Principal Recipient (PR) has demonstrated experience in managing previous Global Fund grants** by working with multiple partners including non-governmental organizations (NGOs) and community-based organizations (CBOs) at the district level.
- **Well described and appropriate private sector involvement.**
- **The proposal highlights innovative strategies** of involving women and thereby enhances gender equality in malaria prevention and control activities, such as the use of Women Malaria Action Groups and Community Health Agents (who are predominantly girls) to be expanded throughout the malaria endemic areas.

- Particular **issues such as cross-border** migrations, rotation of insecticides, pharmacovigilance **are adequately addressed.**
- **Plans for operational research to provide strong scientific evidence** to be used for decision making and policy change are well articulated.
- The program implementation will be driven by a consortium of NGOs and proposes to strengthen local community-based organizations (CBO)/community-based services (CBSs) in the implementation of the strategies.
- **Gender issues have been addressed** in the proposal, including gender focus in BCC strategy to address special vulnerability of women, use of female counselors, free distribution of ITNs during antenatal care (ANC) visits and plans for the disaggregation of data by age and sex.

8.2 Weaknesses

- **The project appears to create parallel structures** for training, supervision, management, monitoring and evaluation, community outreach, etc.
- The **ambitions of the program** may only be sustainable with significant health systems strengthening, particularly on the side of Human Resources for Health (HRH). The magnitude of the combined Round 9 proposals demands significant strengthening efforts, which in itself may **overstretch the capacity** in the short and middle term.
- The **ambitiousness of the proposal** in the context of the extremely **poor performance** and **low capacity** exhibited by the PR in the implementation of the Round 7 grant suggests that this is not a feasible program at this point in time.
- The proposal cover page indicates that there is an **intention to consolidate** the proposed grant with the existing Round 7 grant. However, there is **little indication in the proposal on how** this will be done. The PR's human resource and infrastructure costs budgeted in this proposal are clearly duplicating funding that is already approved under the Round 7 grant.
- There is considerable detail in the service delivery text on how the health system's organization and infrastructure will in principle be organized to implement the diverse and increased activities. **The section lacks a discussion of the feasibility, realism and timing of such multifaceted capacity strengthening,** and Plan Niger International's capacities are not integrated. **The document lacks an overarching analysis** of how to get from the present situation to the new structure and operations, and the issues and constraints that will need to be addressed for this transition to be successful. Lessons learned from the malaria program generally, and the implementation of earlier Global Fund grants in particular, which appear (rather weakly) in sections 4.3.2 and 4.5.3, should be developed.
- **A dedicated project management unit solely for the Round 9 (section 4.9.6) is inappropriate** in view of overlaps with the Round 5 and the Round 7 and the other ongoing interventions against malaria. The proposal discusses the division of responsibilities for implementation, but lacks a discussion of the implied capacity strengthening needs and how to achieve these.
- Given the **poor performance of previous and current Global Fund grants,** the TRP is concerned about the **proposed extensive scale up of activities** in the R9 proposal, as it is not clear how this will be achieved.
- **The roles of Sub-Recipients are poorly defined.** It is unclear how their responsibilities will complement and not duplicate each other.
- Given that the Round 9 proposal will provide services in areas previously covered by the Round 4 grant, **it is unclear if the amount of support for the "Health Work Force"** (which includes technical assistance, M&E assistance, planning and administration assistance, office infrastructure and equipment) is necessary (US\$ 31.8 million of US\$ 113.7 million (Table 5.3). The 5 year budget of US\$ 26.5 million for support to the PR1 and PR2 (SDA 4.1.1) at the national, regional, state and sentinel sites for administrative offices and personnel (not including training costs) seems excessive, particularly as the Round 9 proposal will be implemented in a subset of the Round 4 implementation area. As this is a regional proposal, administration support should focus on the regional and district level.
- **The Global Fund is expected to provide 93 percent** of funding for implementation of the proposal (National Malaria Strategic Plan) with Government of Education providing about 5 percent (UNICEF expected to provide 2 percent). **This data raise the issues of sustainability of planned interventions.**

- It is proposed to divide the country into **six implementation zones** whereby six different international NGOs will implement the program. This **proposal misses the critical country-specific context and does not provide succinct, convincing justification** as to why this was seen as the best approach to implement a comprehensive malaria control strategy. This approach raises two important technical issues: i) how does this division reflect and impact malaria epidemiology in; and ii) overall strengthening sustainability of malaria control in the country in the absence of any clear involvement of the national malaria control program in coordination with the implementation.
- The **activities under Objective 2** (coordination and partnership development at national, community, and public-private levels) **are not clearly justified or described.**
- Considering the rather low rate of **ANC attendance** (approximately 75 percent), interventions **could have been planned to better reach** those who do not attend.
- The **description of the mechanisms for measuring progress to pre-elimination strengthening is not provided** (Guidance for the countries to assess which stage they have reached in the vision of elimination are available from WHO).
- **The proposal does not address the** “prevailing situation of critical shortage of human resources in the region and the fact that the region is cognizant of the problem, this proposal leaves this problem for Member States to work out.”
- Sub-recipient (SR) (Ministry of Health and districts) involvement is limited to “aspects of training and ensuring that the transport provided by the TZMI Project are well taken care of and maintained” as well as to retain health workers.

8.2a Minor weaknesses

- *There are multiple line items in the detailed budget with the same descriptions.*
- *The Home Based Management of Malaria strategy is focusing only on malaria, although burden of malaria has decreased sharply.*

8.3 Recommendations

- **Provide more specific information on the CBOs that will be implementing** the activities described, including details about the composition and how they were selected.
- **Please describe in some detail how the pharmacovigilance component and the monitoring of the quality of ACTs and RDT will be carried out.**
- **Please justify management costs at national level including TAs** to be procured, together with training for management staff, office equipment and other expenses identified. Please provide a justification for the X sentinel sites for in-patients.